Comprehensive State Plan

2008-2014

Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services

December 6, 2007

Comprehensive State Plan
2008-2014
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Comprehensive State Plan 2008-2014
Executive Summary

The Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services has developed the Comprehensive State Plan 2008-2014 to fulfill its statutory responsibility under § 37.2-315 of the *Code of Virginia* to produce and biennially update a six-year plan for mental health, mental retardation, and substance abuse services. This plan must identify services and supports needed by persons with mental illnesses, intellectual disabilities, or substance use disorders across Virginia, define resource requirements, and propose strategies to address these needs.

Services System Overview: Title 37.2 of the *Code of Virginia* establishes the Department as the state authority for mental health, mental retardation, and substance abuse services. The mission of the Department's central office is to provide leadership and service to improve Virginia's system of quality treatment, habilitation, and prevention services for individuals and their families whose lives are affected by mental illness, intellectual disabilities, or substance use disorders (alcohol and other drug dependence or abuse). The Department seeks to promote dignity, choice, recovery, and the highest possible level of participation in work, relationships, and all aspects of community life for these individuals and is committed to implementing the vision "of a consumer-driven system of services and supports that promotes self-determination, empowerment, recovery, resilience, health, and the highest possible level of individual participation in all aspects of community life, including work, school, family and other meaningful relationships" *(State Board Policy 1036 (SYS) 05-3).*

Virginia's public services system includes 16 state facilities and 39 community services boards and one behavioral health authority (referred to as CSBs). CSBs are established by local governments and are responsible for delivering community-based mental health, mental retardation, and substance abuse services, either directly or through contracts with private providers. They are single points of entry into publicly funded mental health, mental retardation, and substance abuse services, with responsibility and authority for assessing individual needs, accessing a comprehensive array of services and supports, and managing state-controlled funds for community-based services. In FY 2006, the CSBs served:

- 118,732 persons for mental health services,
- 26,893 for mental retardation services, and
- 52,416 for substance abuse services, for an unduplicated total of
- 176,276 individuals who received some type of behavioral health service.

The number of individuals served by CSBs has increased in all three services areas from previous plan levels and, overall, has grown 5.5 percent in last two years. Despite significant increases in individuals served, the CSBs continue to confront waiting lists for services. Between January and April 2007, more than 14,000 individuals were waiting to receive at least one CSB service.

The 16 state facilities provide highly structured intensive inpatient treatment and habilitation services. Current operating bed capacities are 1,671 for state hospitals (excluding the Hiram Davis Medical Center, with an operating capacity of 87 beds and the Virginia Center for Behavioral Rehabilitation with an operating capacity of 94 beds) and 1,551 for training centers. In FY 2007, the state facilities served a total of 7,301individuals, which was a 1.7 percent decrease from FY 2005.

Funding for Virginia's public behavioral health and intellectual disabilities services system comes from a variety of sources, including state general funds, local matching dollars, grants,

fees, and Medicaid reimbursement. Medicaid reimbursement is the only Department funding resource that has grown steadily over the last four biennia. As a result of this steady increase, the percentage of the Department's total budget represented by Medicaid revenues have grown from 39% (in FY 2000) to 48 percent in FY 2006.

In FY 2006, the Department's total expenses were almost $1.65 billion, of which

- $1,055.1 million (64 percent) was allocated to CSBs,
- $559.7 million (34 percent) was allocated to state facilities, and
- $30.0 million (2 percent) was allocated to the Department's central office.

In the past two years, the distribution of resources has shifted; the Department is allocating a greater percentage of its funds to community behavioral health support efforts (62 percent in FY 2004 as compared to 64 percent in FY 2006). The Department's administrative expenses have remained a very modest 2 percent of its overall expenses.

Estimated Prevalence: By applying prevalence rates from national epidemiological studies and the 2004 and 2005 National Household Surveys on Drug Use and Health to 2005 Final Estimated Population data, the Department estimates that:

- Approximately 308,037 Virginia adults have had a serious mental illness at any time during the past year.
- Between 84,923 and 103,794 Virginia children and adolescents have a serious emotional disturbance, with between 47,179 and 66,051 exhibiting extreme impairment.
- Approximately 69,470 Virginians (age 6 and older) have mental retardation and 18,622 infants, toddlers, and young children (birth through age 5) have developmental delays requiring early intervention services.
- Approximately 174,865 Virginia adults and adolescents (age 12 and older) abuse or are dependent on any illicit drug, with 119,744 meeting the criterion for dependence, and 467,573 adults and adolescents abuse or are dependent on alcohol, with 209,711 meeting the criterion for dependence.

Only a portion of persons with diagnosable disorders will need services at any given time and an even smaller portion will require or seek services from the public sector.

Critical Issues and Strategic Directions: The Plan details seven critical issues facing the Commonwealth and identifies 43 goals, supporting objectives, and action steps to achieve the Department's mission and vision. Strategic directions and goals for each critical issue follow.

Transforming Virginia's System of Care:

Strategic Directions	
➢ The Department's Integrated Strategic Plan and Vision for the Future Services System in Virginia ➢ The Governor's Transformation Initiative	
Goal	
1	Implement a recovery and resilience-oriented and person-centered system of services and supports.

Implementation of Self-Advocacy, Self-Determination, Recovery, Resilience, and Person-Centered Principles and Practices:

Strategic Directions
➢ Consumer and family member involvement ➢ Consumer and family education and leadership training

➢ Peer provided services and supports ➢ Person-centered practices ➢ Advocacy for individuals with mental health, intellectual disabilities, and/or substance use disorders	
Goals	
2	Increase opportunities for individual and family involvement.
3	Improve opportunities for individual and family education and training.
4	Promote and support the implementation of mental health programs that foster empowerment, peer support, and recovery-based services.
5	Provide individuals and families with the opportunity, at the systems and individuals levels, to determine the types of mental retardation services and supports they receive and to evaluate the quality of those services.
6	Reduce the stigma and shame associated with substance use disorders that inhibit people from seeking help and restrict resources that support treatment and prevention.

Access to Services and Supports That Meet Individual Needs:

Strategic Directions ➢ Olmstead Decision Implementation ➢ Response to and Recovery from the Virginia Tech Tragedy ➢ Expand and Sustain Services and Supports Capacity ➢ Mental Retardation Services System Study ➢ Service Issues and Needs of Special Populations ➢ Evidence-Based and Best Practices ➢ Recovery-Oriented and Person-Centered Services in State Facilities	
Goals	
7	Promote the concepts of treatment in the most integrated settings and individual and family choice that are central to the U.S. Supreme Court Olmstead decision.
8	Expand and sustain services capacity necessary to provide services that promote recovery, resilience, self-determination, and person-centered planning when and where they are needed, in appropriate amounts, and for appropriate durations.
9	Promote the establishment of an integrated system of service delivery that implements the core values of resilience, self-determination, and person-centered planning and is responsive to the mental health, mental retardation, and substance abuse needs of children and adolescents and their families.
10	Promote the development of a comprehensive array of specialized prevention and treatment services and supports for older adults with mental health and substance use disorders.
11	Enhance Virginia's capacity to intervene and divert individuals with mental illness or substance use disorders from the criminal justice system and provide behavioral health evaluation and treatment services to individuals involved with the criminal justice system.
12	Assure that CSBs are aware, prepared, and have sufficient resources to address growing demands among veterans of pos-9/11 deployment and current members of the Virginia National Guard.
13	Provide individualized treatment services in a secure environment to individuals civilly committed to the Department as sexually violent predators.
14	Improve the quality and appropriateness of support and treatment for persons with a diagnosis of co-occurring mental retardation and mental illness
15	Provide appropriate assessments, interventions and specifically designed programming to persons with co-occurring diagnoses of mental illnesses and substance use disorders.

16	Ensure quality and continuity of care for people who are deaf, hard of hearing, late deafened, or deafblind and are in need of mental health, mental retardation, or substance abuse services.
17	Promote and support the implementation of evidence-based practices.
18	Assure that state hospitals and training centers provide quality assessment, treatment, rehabilitation, training, and habilitation services that are appropriate to the needs of individual patients and residents.
19	Ensure that CSB prevention services address risk and protective factors and service gaps identified by community-based prevention planning coalitions.
20	Reduce the incidence and prevalence of suicide among youth and adults in Virginia.
21	Continue to reduce youth access to tobacco products.
22	Enable Virginia's mental health, mental retardation, and substance abuse service systems to better understand and prepare for the heightened threat potential facing the Commonwealth.
23	Establish structures and relationships that assure an immediate, effective, and coordinated response to terrorism-related and other major disasters by the mental health, mental retardation, and substance abuse services system.

Partnerships for Services System Transformation:

Strategic Directions ➢ State and Local Interagency Partnerships ➢ Partnerships with Private Providers ➢ Partnerships with CSBs and Local Governments ➢ System Leadership Council	
Goals	
24	Realize cost savings to the Commonwealth by expanding Medicaid funding for community mental health, mental retardation, and substance abuse services.
25	Increase the stability of families affected by mental illnesses and substance use disorders that are receiving TANF benefits or are involved in protective services.
26	Provide safe and affordable housing that meets the needs of individuals receiving mental health, mental retardation, or substance abuse services.
27	Improve the physical health and wellness of individuals receiving mental health, mental retardation, or substance abuse services.
28	Reduce barriers to employment for youth and adults with mental disabilities.
29	Improve competitive employment opportunities and outcomes for individuals receiving health, mental retardation, or substance abuse services.
30	Encourage and facilitate greater private provider participation in the public health, mental retardation, or substance abuse service system.

Infrastructure and Technology:

Strategic Directions ➢ State Facility Capital Improvements and Replacements or Renovations that Meet Consumer Needs ➢ Relationship with VITA and Northrop-Grumman ➢ Electronic Health Records	
Goals	
31	Assure that the capital infrastructure of state hospitals and training centers is safe, appropriate for the provision of current service methods, and efficient to operate.

32	Improve the ability of the Department, state facilities, and CSBs to manage information efficiently in an environment that is responsive to the needs of users and protects identifiable health information for individuals receiving public mental health, mental retardation, or substance abuse services.

Human Resources Management and Development:

Strategic Directions ➢ Response to Changing Workforce Demographics and Skill Requirements ➢ Workforce Competitiveness ➢ Creation of an Agency-wide High Performance Organization	
Goals	
33	Partner with public and private organizations and providers to address systemic issues in recruiting and retaining workforce within mental health, mental retardation, and substance abuse services system.
34	Assure that the service system workforce is competent and well trained to provide quality services and supports.

Service Quality and Accountability

Strategic Directions ➢ Assurance of Service Quality, Effectiveness, and Appropriateness ➢ Licensing and Human Rights Expectations ➢ Technology Enhancements ➢ Utilization Techniques ➢ Performance and Outcomes Measurement	
Goals	
35	Enhance the Department's oversight of quality of care and protection of individuals receiving mental health, mental retardation, substance abuse, developmental disabilities, or brain injury services.
36	Implement a high quality, effective, efficient, and responsive human rights system that protect the rights of each individual receiving services from providers of mental health, mental retardation, or substance abuse services.
37	Promote the use of non-coercive techniques and reduce the use of seclusion and behavioral restraint in state facilities and community services.
38	Ensure that Department and state facility quality management review functions are implemented according to clearly articulated policies and procedures
39	Assure that publicly funded services provided in state facilities and CSBs are based on sound research that assures the highest quality treatment and the best clinical outcomes for individuals.
40	Achieve a learning environment that promotes quality care and safety of individuals receiving services in state facilities.
41	Implement a comprehensive and consistent system-wide approach to public mental health utilization management.
42	Improve the medication practices of physicians, pharmacists, and nurses who have a role in the medication management process in community and state facility services.
43	Document the successful implementation of the Transformation Initiative

Summary of Resource Requirements

The Department, in concert with various commissions, panels, and studies, has identified the following resource requirements to respond to critical issues facing Virginia's behavioral health and intellectual disabilities services system. The resource requirements listed in the plan are far

more extensive than in the past years due to the numerous commissions, panels and studies that have published funding recommendations in the last year. However, given the current budget constraints facing the Commonwealth, the Department recognizes that addressing these needs will require a multi-biennia investment of resources.

Post VA Tech Service Access and Accountability Initiatives: Investigations following the Virginia Tech critical incident by the Virginia Tech Review Panel and the Office of the Inspector General (OIG) revealed major gaps in service capacity across the Commonwealth, particularly in the areas of emergency and crisis stabilization services, outpatient services, and case management. Additionally, the Department's previous experiences with community reaction to mass violence (9/11) demonstrate the need for extended crisis counseling services. The estimated costs of fully implementing service access and accountability recommendations resulting from the Tech tragedy would be 74 million dollars annually.

Child and Adolescent Services: The report of the Child and Family Behavioral Health Policy and Planning Committee, established to meet the requirements of Budget item 311-E, includes an array of recommendations to address the behavioral health needs of children and their families. The estimated costs of fully implementing this committee's recommendations would be almost 116 million dollars annually.

Geriatric Services: Virginia is experiencing a dramatic increase in the number of citizens who are over the age of 65. The Department has initiated pilot projects in two regions that are designed to develop community-based services and supports to divert and discharge older adults from state geriatric psychiatric facilities. To expand regional projects to the remaining regions would require 5 million dollars annually.

MR Services System Study Recommendations: The 2006 General Assembly directed that a collaborative effort between the Department, DMAS, the Virginia Association of Community Services Boards (VACSB), the Arc of Virginia, and other stakeholders, review the current Medicaid MR waiver to determine how the waiver could be improved. The 2007 General Assembly expanded this study to include the entire system of intellectual disability services delivery in Virginia. The study identified gaps and barriers and identified resource requirements totaling almost 290 million dollars annually.

Forensic Services: The Department estimates that to fully implement the "Sequential Intercept" approach developed by experts leading the national initiative to improve mental health treatment for individuals with justice system involvement would require 25 million dollars annually.

Unmet Community Services Needs (Waiting Lists): To support the provision of community mental health, mental retardation, and substance abuse day support, employment, and residential services to adults and adolescents or children on CSB waiting lists for those services would require 183.3 million dollars annually.

State Facility Transformation Needs: To divert individuals from admission to Eastern State Hospital and facilitate the discharge of patients who can be served in community settings will require 5 million dollars annually. The expanded Center for Behavioral Rehabilitation will require 6.3 million dollars annually to operate at its projected increased capacity. To provide a four percent adjustment to offsets higher operational (non-personnel) costs in state facilities would cost 3.4 million dollars annually.

Behavioral Health Services for Veterans: A substantial increase in behavioral health service capacity within Virginia will be needed to address the demand for services among veterans of post-9/11 deployments. To increase the Commonwealth's behavioral health

service capacity to meet the needs of veterans would require an initial investment of 26.7 million dollars and an ongoing annualized investment of at least 8 million dollars.

Suicide Prevention Plan Implementation: In 2005, the Department assumed lead agency responsibility for the implementation of the *Suicide Prevention Across the Lifespan for the Commonwealth of Virginia* (see Senate Document 17, 2004). Funds totaling 3 million dollars annually would be needed to implement the recommendations of this plan.

System Transformation Training and Development: Workforce and organizational development activities are fundamental to supporting and sustaining Virginia's service system transformation initiative. To establish partnerships with one or more Virginia universities to develop "Centers of Excellence" in workforce and organizational development to advance values, principles, and practices that support self-determination and recovery across the services system and training and certification of CSB staff and relevant partners involved in the involuntary civil commitment process would cost 0.5 million dollars annually.

Direct Service Associate and Nursing Professional Career Pathways: To implement workforce initiatives for direct service associates and nursing staff to assure quality of care in state facilities would cost 4 million dollars annually.

Northern Virginia State Facility Workforce Shortages: Workforce shortages in the local labor market, significant gaps between market competitors' and state salaries, and the escalating cost of living in Northern Virginia have combined to adversely affect the ability of the two state facilities in the region to recruit and retain mission-critical positions. To grant salary adjustments to employees in positions with the highest market variance, turnover and vacancy and turnover rates at these two state facilities would require 3.7 million dollars annually.

Multicultural Competency: To provide culturally competent supports for a diverse workforce and train providers to more effectively address the needs of diverse communities; thereby improving service access for people from different cultures would require 0.2 million dollars annually.

Electronic Health Records: To purchase and implement a comprehensive behavioral healthcare clinical records application would require 2.5 million dollars annually.

Conclusion*:* The directions established in the *Comprehensive State Plan for 2008-2014* would enable the Commonwealth to accelerate the transformation of the public services system to a more completely community-based system of care while preserving the important service responsibilities of state hospitals and training centers. The policy agenda for the next biennium continues to focus, to the extent possible, on sustaining the progress that has been achieved during the past four years in implementing the vision for the future mental health, mental retardation, and substance abuse services system and investing in services capacity and infrastructure needed to address issues facing the services system.

Comprehensive State Plan
2008 - 2014

I. INTRODUCTION

Section 37.2-315 of the C*ode of Virginia* requires the Department of Mental Health, Mental Retardation and Substance Abuse Services (the Department) to develop and update biennially a six-year Comprehensive State Plan for mental health, mental retardation, and substance abuse services. This plan must identify the services and supports needs of persons with mental illnesses, mental retardation, or substance use disorders across Virginia; define resource requirements; and propose strategies to address these needs. That *Code* section also requires that the plan be used in the preparation of the Department's biennium budget submission to the Governor.

The Department's initial Comprehensive State Plan for 1985-1990 proposed a "responsible transition" to a community-based system of services. In 1986, the plan was expanded to cover a six-year time frame, with updates corresponding to the Department's biennium budget submissions. These updates continued until 1995, when agency strategic planning efforts replaced the 1996-2002 Comprehensive State Plan. Biennial updates to the Comprehensive State Plan were reinstated in 1997 with the completion of the 1998-2004 Plan.

The Department's Comprehensive State Plan has evolved to serve a number of purposes. The plan:

- Establishes services system priorities and future system directions for the public mental health, mental retardation, and substance abuse services system;
- Describes strategic responses to major issues facing the services system;
- Identifies priority service needs;
- Defines resource requirements and proposes initiatives to respond to these requirements; and
- Integrates the agency's strategic and budget planning activities.

The 2000-2006 Comprehensive State Plan introduced an individualized database to document service needs and characteristics of individuals on community services board (CSB) waiting lists. This biennial survey continues to be used to document community service needs. CSB waiting lists include individuals who have sought but are not receiving CSB services and current recipients of CSB services who are not receiving the types or amounts of services that CSB staff have determined they need. The CSB waiting list database provides demographic and service need information about each individual identified as needing community services or supports. Also included in the database are the CSBs' average wait times for accessing specific types of services and prevention service priorities.

In addition to CSB waiting list information, the Department maintains state facility "ready for discharge" lists. These include patients in state hospitals whose discharges have been delayed due to extraordinary barriers and residents of state training centers who, with their authorized representative or family member, have chosen to continue their training and habilitation in the community instead of at a training center.

The 2008-2014 Comprehensive State Plan continues to build on the recommendations of the Department's Integrated Strategic Plan (ISP). Additionally, key initiatives in this Plan also are incorporated in the Agency Strategic Plan (ASP) and associated Service Area Plans prepared as part of the 2008-2010 biennium budget submission to the Department of Planning and Budget.

- The ISP is the product of a two-year strategic planning process that has involved hundreds of interested citizens. The ISP provides a framework for transforming Virginia's publicly funded mental health, mental retardation, and substance abuse services system.
- Using a uniform structure and cross-agency taxonomy of state programs and activities provided by the Department of Planning and Budget, the Department's ASP is intended to align the Department's vision, goals, services, objectives, and resource plans with the guiding principles, long-term vision, and statewide objectives established by the Council for Virginia's Future. The Council was established by §2.2-2684 of the *Code of Virginia* to advise the Governor and the General Assembly on the implementation of the Roadmap for Virginia's Future process.

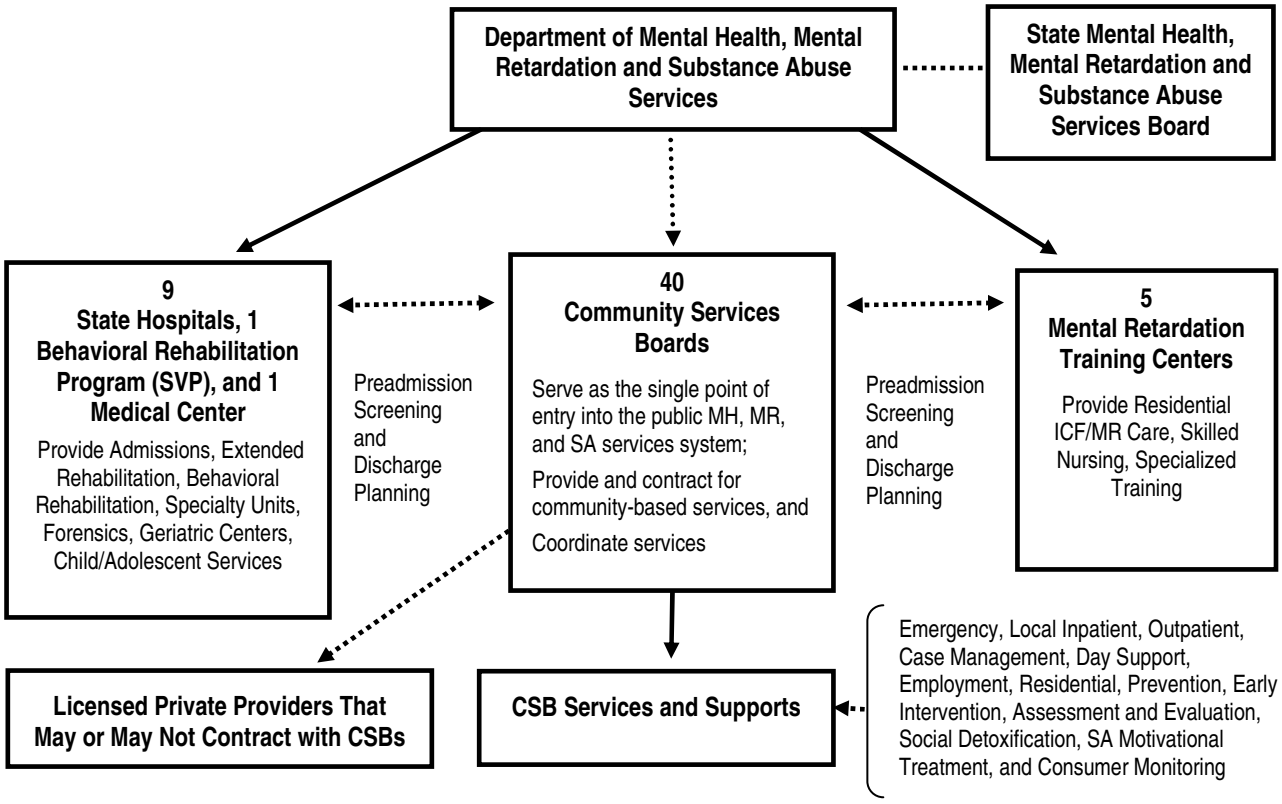
The draft 2008-2014 Comprehensive State Plan was placed on the Department's website for public review and comment on November 1, 2007. Copies also were provided to individuals upon request. On November 27, 2007, the State Mental Health, Mental Retardation and Substance Abuse Services Board and Department conducted a statewide videoconference public hearing to receive public comment on the draft Plan. This videoconference public hearing was broadcast to five sites: Chesterfield, Lynchburg, Hampton, Falls Church, and Marion. A sixth hearing in Charlottesville also was held. Across the Commonwealth, 22 individuals attended the hearing, with seven individuals speaking. In addition to the comments received at the public hearing, the Department received nine comments by mail, fax, or email. At its December 6, 2007 meeting, the State Board reviewed public hearing testimony and other comments received on the draft Plan and considered changes proposed by the Department in response to this public comment.

II. SERVICES SYSTEM OVERVIEW

Services System Structure and Statutory Authority

Virginia's public services system includes the Department, the State Mental Health, Mental Retardation, and Substance Abuse Services Board (the State Board), 16 state operated hospitals and training centers operated by the Department, and 39 community services boards and one behavioral health authority (referred to as CSBs) that provide services directly or through contracts with private providers. Maps of CSB service areas and the locations of state facilities are contained in Appendix A.

The following diagram outlines the relationships between these services system components. Solid lines depict a direct operational relationship between the involved entities (e.g., the Department operates state facilities). Broken lines depict non-operational relationships (e.g., policy direction, contracting, or coordination).



Title 37.2 of the *Code of Virginia* establishes the Department as the state authority for mental health, mental retardation, and substance abuse services. By statute, the State Board offers policy direction for Virginia's services system.

The mission of the Department's central office is to provide leadership and service to improve Virginia's system of quality treatment, habilitation, and prevention services for individuals and their families whose lives are affected by mental illness, mental retardation, or substance use disorders (alcohol and other drug dependence or abuse). The central office seeks to promote dignity, choice, recovery, and the highest possible level of participation in work, relationships, and all aspects of community life for these individuals.

Responsibilities of the Department include:

- Providing leadership that promotes strategic partnerships among and between CSBs, state facilities, and the central office and effective relationships with other agencies and providers;

- Providing direct care, treatment, and habilitation services in state hospitals (civil and forensic) and training centers;
- Supporting the provision of accessible and effective community mental health, mental retardation, and substance abuse treatment and prevention services through the network of CSBs;
- Assuring that public and private mental health, mental retardation, and substance abuse services providers adhere to licensing standards; and
- Protecting the human rights of individuals receiving mental health, mental retardation, or substance abuse services.

Characteristics of Community Services Boards and Trends

Community services boards (CSBs) function as the single points of entry into publicly-funded mental health, mental retardation, and substance abuse services, including access to state hospital and training center (state facility) services through preadmission screening, case management and coordination of services, and discharge planning for individuals leaving state facilities. Community services boards:

- provide services, directly and through contracts with other providers;
- are the local focal points of programmatic and financial responsibility and accountability for publicly-funded services;
- are community educators, organizers, and planners and serve as advocates for individuals receiving CSB services and persons in need of services; and
- serve as advisors to the local governments that established them.

The private sector is a vital partner with CSBs in serving people with mental illnesses, mental retardation, or substance use disorders. In addition to serving many individuals through contracts with CSBs, private providers also serve other individuals directly, for example through various Medicaid programs such as the mental retardation home and community-based waiver (MR waiver), with plans of care case managed by CSBs, and mental health clinic and inpatient psychiatric treatment services.

Section 37.2-100 of the *Code of Virginia* defines three types of CSBs: operating CSBs, administrative policy CSBs, and policy-advisory CSBs with local government departments (LGDs). Chapter 6 in Title 37.2 of the *Code* authorizes certain localities to establish behavioral health authorities (BHAs). In this Plan, CSB or community services board means CSB, BHA, and local government department with a policy-advisory board.

Combined Classification of Community Services Boards

CSB Classification	Functions as LGD	Cities and/or Counties Served One	Two or More	Total CSBs
Administrative Policy CSBs[1]	7	7	3	10
LGD with Policy-Advisory CSB	1	1	0	1
Operating CSB[2]	0	2	26	28
Behavioral Health Authority[2]	0	1	0	1
TOTAL CSBs	8	11	29	40

[1] Seven of these CSBs are city or county departments; even though 3 CSBs are not, all use local government employees to staff the CSB and deliver services.

[2] Employees in these 28 CSBs and in the BHA are board, rather than local government, positions.

CSBs are not part of the Department. The Department's relationships with all CSBs are based on the community services performance contract, provisions of Title 37.2 of the *Code of*

Virginia, State Board policies and regulations, and other applicable state or federal statutes or regulations. The Department contracts with, funds, monitors, licenses, regulates, and provides consultation to CSBs.

CSB Mental Health Services

In FY 2006, 118,732 individuals received CSB mental health services. This represents an unduplicated count of all individuals receiving any mental health services. Numbers of individuals receiving CSB mental health services by core service follow.

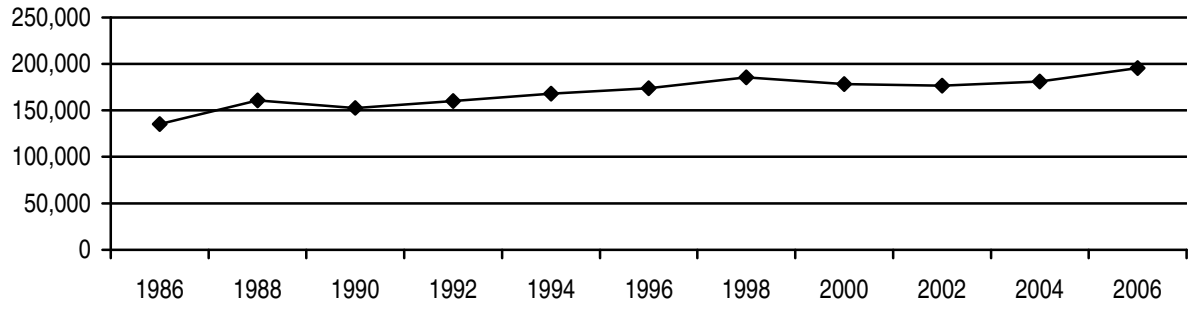
Number of Individuals Receiving CSB Services by MH Core Service in FY 2006

Core Service	# Served	Core Service	# Served
Emergency Services	**43,830**	Highly Intensive Residential	1,040
Local Inpatient Services	**2,787**	Intensive Residential	339
Outpatient Services	76,443	Supervised Residential	1,489
Assertive Community Treatment	1,401	Supportive Residential	4,812
TOTAL Outpatient Services	**77,844**	**TOTAL Residential Services**	**7,680**
Case Management	**47,972**	**Early Intervention Services**	**552**
Day Treatment/Partial Hospitalization	2,902	Motivational Treatment Services	3
Rehabilitation Services	5,608	Consumer Monitoring Services	1,891
TOTAL Day Support Services	**8,510**	Assessment and Evaluation Services	3,826
Sheltered Employment Services	53	**TOTAL Limited Services**	**5,720**
Supported Employment - Group Models	38	**TOTAL Individuals Served**	**195,794**
Individual Supported Employment	808	**TOTAL Unduplicated Individuals**	**118,732**
TOTAL Employment Services	**899**		

Source: FY 2006 Community Services Performance Contract Annual Reports, Department.

Between FY 1986 (the first year that annual performance contract data was submitted by CSBs) and FY 2006, the numbers of individuals receiving various CSB mental health services grew from 135,182 to 195,794, an increase of 45 percent. Trends in the numbers of individuals receiving mental health services from CSBs are displayed on the following graph.

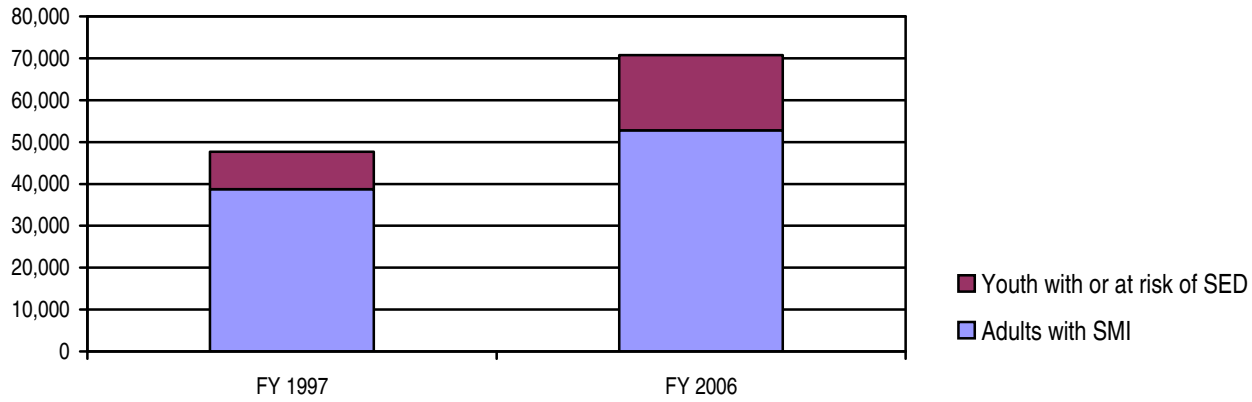
Trends in Numbers of Individuals Receiving MH Services From CSBs
FY 1986 - FY 2006



These numbers are duplicated counts of individuals receiving services because they are derived from CSB community services performance contract annual reports that display numbers of people receiving services by core service categories.

CSBs continue to serve more consumers with more severe disabilities. In FY 1997, CSBs served 38,787 adults with serious mental illness (SMI) and 8,922 youth with or at risk of serious emotional disturbance (SED); in FY 2006, CSBs served 52,799 adults with SMI and 17,955 youth with or at risk of SED. This represents a 36 percent increase in the numbers of adults with SMI and a 101 percent increase in the numbers of youth with or at risk of SED served by CSBs between FY 1997 and FY 2006.

Numbers of Adults with SMI and Youth with or At-Risk of SED Served by CSBs FY 1997 and FY 2006



Between FY 1997 and FY 2006, the percent of adults with SMI and youth with or at risk of SED increased from 41.4 percent to 59.9 percent of the total number of individuals with mental illnesses served by the CSBs.

CSB Mental Retardation Services

In FY 2006, 26,893 individuals received CSB mental retardation services. This represents an unduplicated count of all individuals receiving any mental retardation services. Numbers of individuals receiving CSB mental retardation services by core service follow.

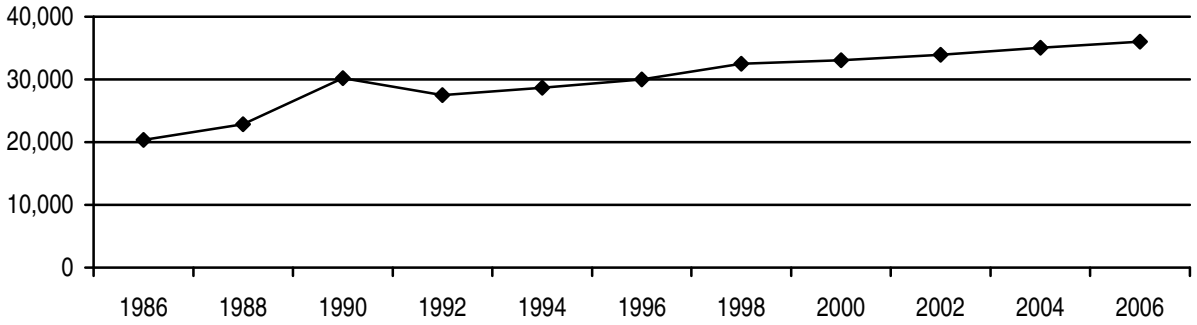
Number of Individuals Receiving CSB Services by MR Core Service in FY 2006

Core Service	# Served	Core Service	# Served
Emergency Services	**41**	Intensive Residential	834
Outpatient Services	**86**	Supervised Residential	543
Case Management Services	**16,228**	Supportive Residential	1,291
Habilitation	2,720	**TOTAL Residential Services**	**2,769**
TOTAL Day Support Services	**2,720**	**Early Intervention Services**	**8,828**
Sheltered Employment Services	905	Consumer Monitoring Services	1,946
Supported Employment - Group Models	676	Assessment and Evaluation Services	453
Individual Supported Employment	1,352	**TOTAL Limited Services**	**2,399**
TOTAL Employment Services	**2,933**	**TOTAL Individuals Served**	**36,004**
Highly Intensive Residential	101	**TOTAL Unduplicated Individuals**	**26,893**

Source: 2006 Community Services Performance Contract Annual Reports, Department.

Between FY 1986 (the first year that annual performance contract data was submitted by CSBs) and FY 2006, the numbers of individuals receiving various CSB mental retardation services grew from 20,329 to 36,004, or by 77 percent. Trends in the numbers of individuals receiving mental retardation services from CSBs are displayed on the following graph.

Trends in Numbers of Individuals Receiving MR Services From CSBs
FY 1986 - FY 2006



These numbers are duplicated counts of individuals receiving mental retardation services because they are derived from CSB community services performance contract annual reports that display numbers of people receiving services by core service categories.

CSB Substance Abuse Services

In FY 2006, 52,416 individuals received services for substance use disorders from CSBs. Numbers of individuals receiving CSB substance abuse services by core service follow.

Number of Individuals Receiving CSB SA Services by Service in FY 2006

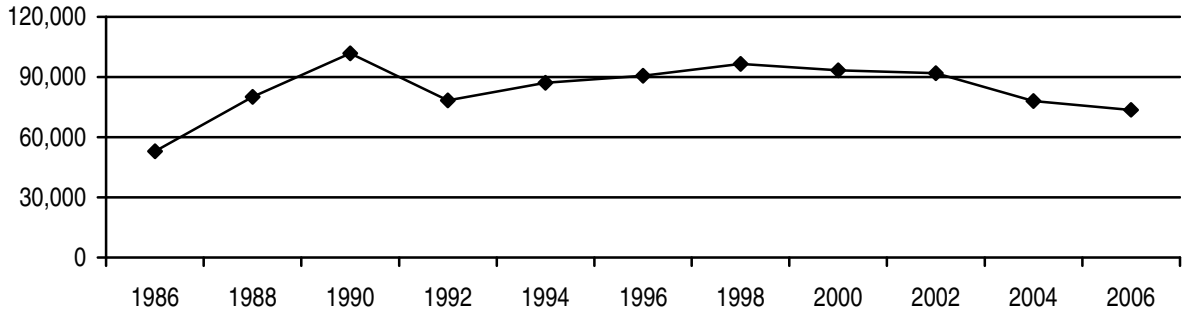
Core Service	# Served	Core Service	# Served
Emergency Services	**7,189**	Intensive Residential	1,604
Local Inpatient	373	Supervised Residential	261
Community Hospital-Based Detox	1,363	Supportive Residential	429
TOTAL Local Inpatient Services	**1,736**	**TOTAL Residential Services**	**5,489**
Outpatient Services	35,077	**Early Intervention Services**	**1,315**
Opioid Detoxification	199	SA Social Detoxification Services	3,312
Opioid Treatment Therapy	1,840	Motivational Treatment	1,002
TOTAL Outpatient Services	**37,116**	Consumer Monitoring Services	823
Case Management Services	**11,587**	Assessment and Evaluation Services	2,474
Day Treatment/Partial Hospitalization	1,590	**TOTAL Limited Services**	**7,611**
TOTAL Day Support Services	**1,590**	**TOTAL Individuals Served**	**73,633**
Highly Intensive Residential	60	**TOTAL Unduplicated Individuals**	**52,416**
Jail-Based Habilitation	3,135		

Source: 2006 Community Services Performance Contract Annual Reports, Department.

Between FY 1986 (the first year that annual performance contract data was submitted by CSBs) and FY 2006, the numbers of individuals receiving various CSB substance abuse services grew

from 52,942 to 73,633, an increase of 39 percent. Trends in the numbers of individuals receiving substance abuse services from CSBs are displayed on the following graph.

Trends in Numbers of Individuals Receiving SA Services From CSBs FY 1986 - FY 2006



These numbers are duplicated counts of individuals receiving mental retardation services because they are derived from CSB community services performance contract annual reports that display numbers of people receiving services by core service categories.

In summary, 198,041 individuals received CSB mental health, mental retardation, and substance abuse services in FY 2006. This represents the unduplicated numbers of individuals served in each program area. With the implementation in FY 2004 of the Community Consumer Submission (software that extracts data on individuals receiving services from CSB information systems and transmits encrypted data to the Department), a totally unduplicated count of individuals receiving services from CSBs across all program areas, rather than in each program area became available for the first time. In FY 2006, 176,276 individuals received services from CSBs. Appendix B contains detailed information on CSB service utilization trends, levels of functioning or disability for individuals served by CSBs in FY 2006, and condensed core services definitions.

Characteristics of State Hospitals and Training Centers and Trends

State Hospitals

State hospitals provide highly structured intensive inpatient services, including a range of psychiatric, psychological, psychosocial rehabilitation, nursing, support, and ancillary services. Specialized programs are provided for geriatric, child and adolescent, and forensic individuals. The Joint Commission for Accreditation of Healthcare Organizations (JACHO) has accredited all state hospitals.

Child and adolescent services provided by the Southwestern Virginia Mental Health Institute (SVMHI) and the Commonwealth Center for Children and Adolescents (CCCA) are licensed under the CORE regulations for residential children's services.

The Hiram Davis Medical Center (HDMC) provides medical and skilled nursing services to individuals receiving state facility services.

The Virginia Center for Rehabilitative Services (VCBR) provides individualized rehabilitation services in a secure facility to individuals who are civilly committed as sexually violent predators.

Operating (staffed) bed capacities on July 5, 2007 and FY 2007 average daily census for the state hospitals follow.

Mental Health Facility Operating Capacities and Average Daily Census

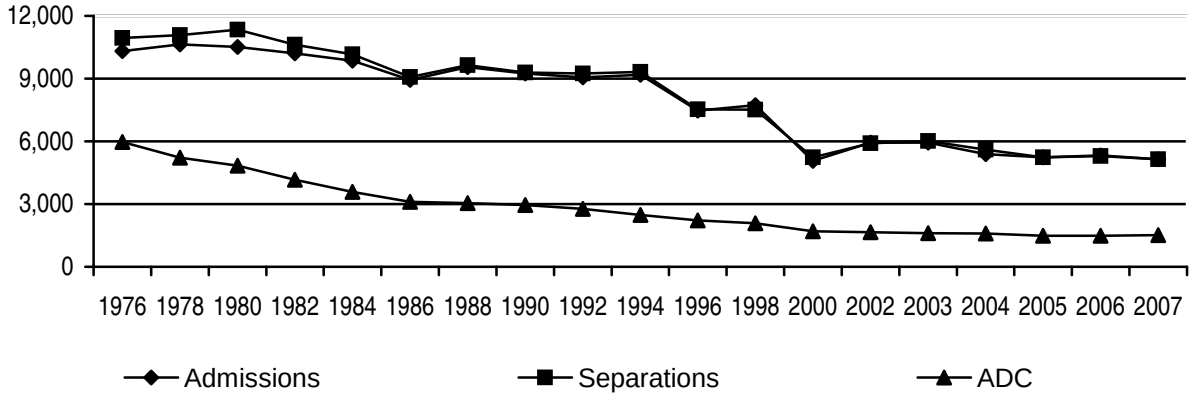
MH Facility	Beds	ADC	MH Facility	#Beds	ADC
Catawba Hospital	120	107	Piedmont Geriatric	135	120
Central State Hospital	277	240	Southern VA MHI	74	69
CCCA	48	34	Southwestern VA MHI	172	151
Eastern State Hospital	456	427	Western State Hospital	260	241
Northern VA. MHI	129	122	Total Operating Capacity (Beds) and ADC	1,671	1,511

Note: HDMC, with an operating capacity of 87 beds and an ADC of 58 and VCBR, with an operating capacity of 94 beds and an ADC of 38 are not included in this table.

Between FY 1976 and FY 1996, the average daily census at state hospitals, excluding the Hiram Davis Medical Center, declined by 3,745, or 63 percent (from 5,967 to 2,222). Between FY 1996 and FY 2007, the average daily census declined by 32 percent (from 2,222 to 1,511). Between FY 1996 and FY 2007, excluding the HDMC and VCBR, admissions declined by 31 percent (from 7,468 to 5,146) and separations (discharges) declined by 32 percent (from 7,529 to 5,149). In FY 2007, VCBR experienced 19 admissions and 2 separations.

Admission, separation, and average daily census trends (FY 1976 - FY 2007) for state hospitals, excluding the HDMC and VCBR, follow.

MH Facility Admissions, Separations, and Average Daily Census (ADC) Trends: FY 1976 - FY 2007



Note: Includes the Virginia Treatment Center for Children through FY 1991, when it transferred to the Medical College of Virginia.

Training Centers

Training centers provide highly structured habilitation services, including residential care and training in areas such as language, self-care, independent living, socialization, academic skills, and motor development for individuals with intellectual disabilities. All training centers are certified by the U.S. Centers for Medicare and Medicaid (CMS) as meeting Medicaid Intermediate Care Facility for the Mentally Retarded (ICF/MR) standards of quality. In addition, Central Virginia Training Center provides skilled nursing services. Operating (staffed) bed capacities on July 5, 2007 and FY 2007 average daily census for each training center follow.

Training Center Operating Capacities and Average Daily Census

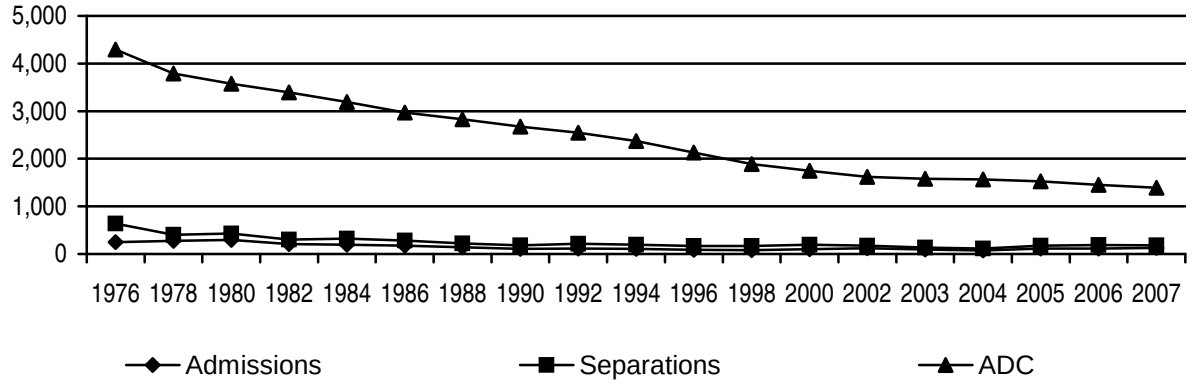
Training Center	Beds	ADC	Training Center	Beds	ADC
Central Virginia Training Center	577	509	Southside Virginia Training Center	359	311
Northern Virginia Training Center	200	172	Southwestern Virginia Training Center	215	209
Southeastern Virginia Training Center	200	187	Total Operating Capacity (Beds) and ADC	1,551	1,389

Between FY 1976 and FY 1996, the average daily census at training centers declined by 2,161, or 51 percent (from 4,293 to 2,132). Between FY 1996 and FY 2007, the average daily census declined by 35 percent (from 2,132 to 1,389). Between FY 1996 and FY 2007, training center admissions increased by 47 percent (from 87 to 128). Between FY 1996 and FY 2007, training center separations (discharges) decreased by 18 percent (from 223 to 182).

Admission to a training center is governed by §37.2-806 of the *Code of Virginia* (regular admission through the judicial certification process) and by §37.2-2.807 and regulations promulgated under that statute (emergency and respite admission for up to 21 days). Applicants must have a diagnosis of mental retardation and deficits in at least two of seven areas of adaptive functioning. Applications are made through the CSB in the locality where the applicant resides. Applicants who meet the criteria for admission to an ICF/MR must be offered the choice of receiving services in an ICF/MR or through the MR waiver.

Admission, separation, and average daily census trends (FY 1976 – FY 2007) for training centers follow.

Training Center Admissions, Separations, and Average Daily Census (ADC) Trends: FY 1976 - FY 2007

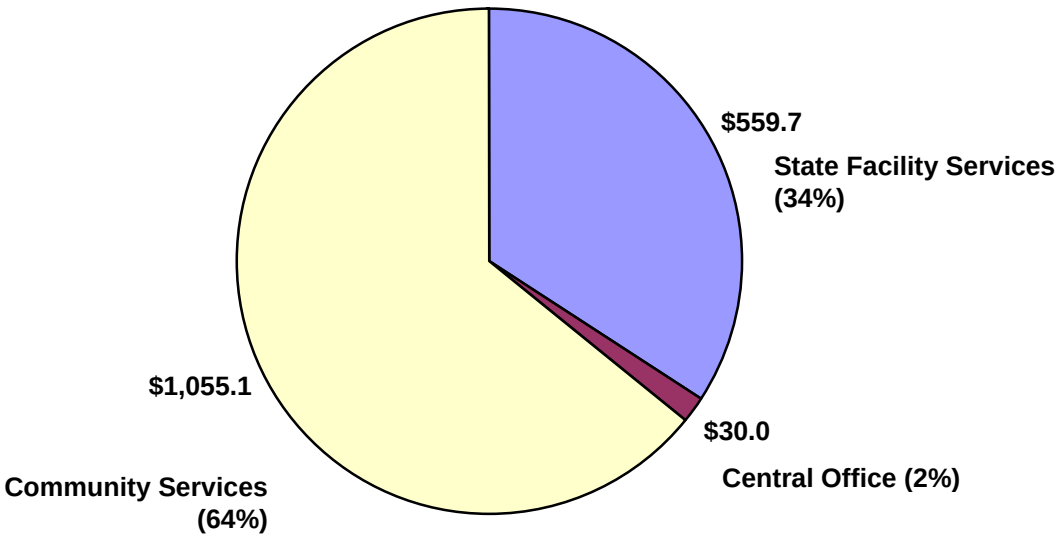


Appendix C contains detailed information on state facility utilization, including the numbers served, average daily census, admissions, separations, and utilization, by CSB.

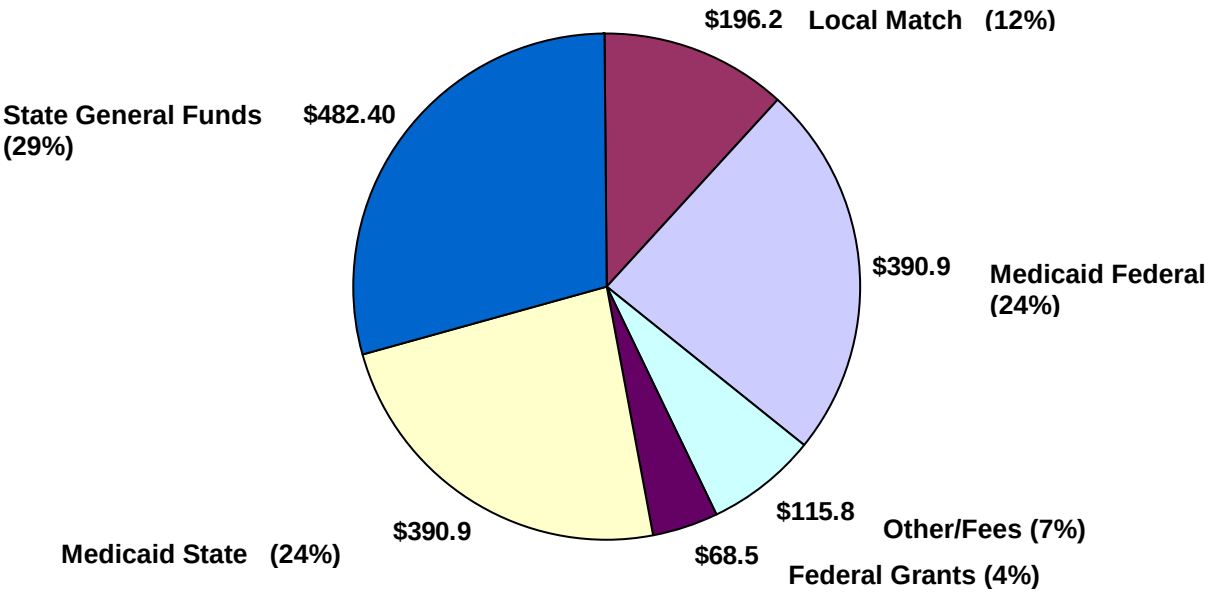
Services System Funding and Trends

Charts depicting the services system's total resources for **FY 2006** from **ALL SOURCES** (rounded and in millions), including the Department's final adjusted appropriation, local matching funds, all fees, and Medicaid MR waiver payments to private vendors, follow.

FY 2006 Total Services System Funding
$1.6448 Billion

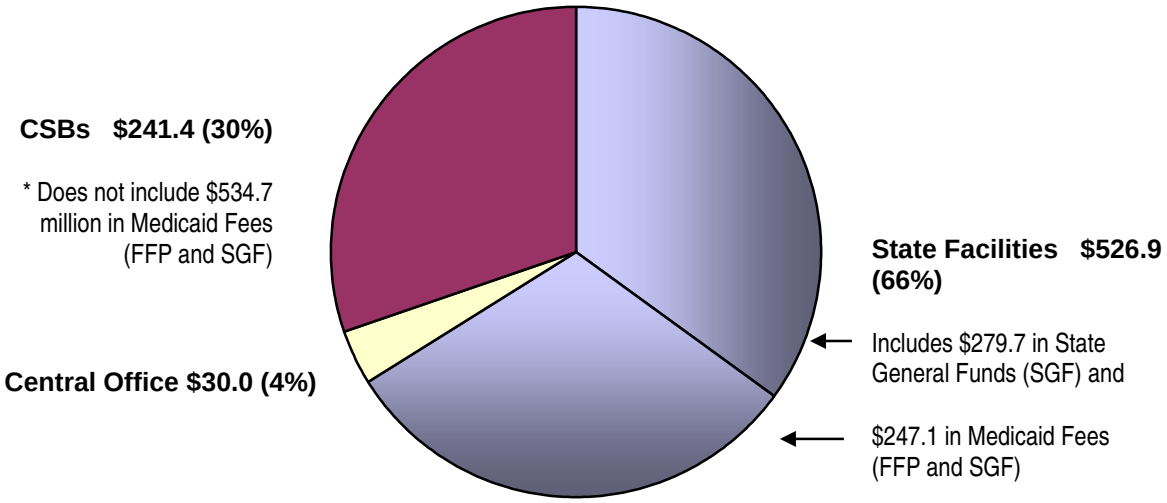


FY 2006 Total Services System Funding by Funding Source
$1.6448 Billion



Dollars in the Charts Above Are in Millions

FY 2006 Total State-Controlled Expenditures
$ 798 Million

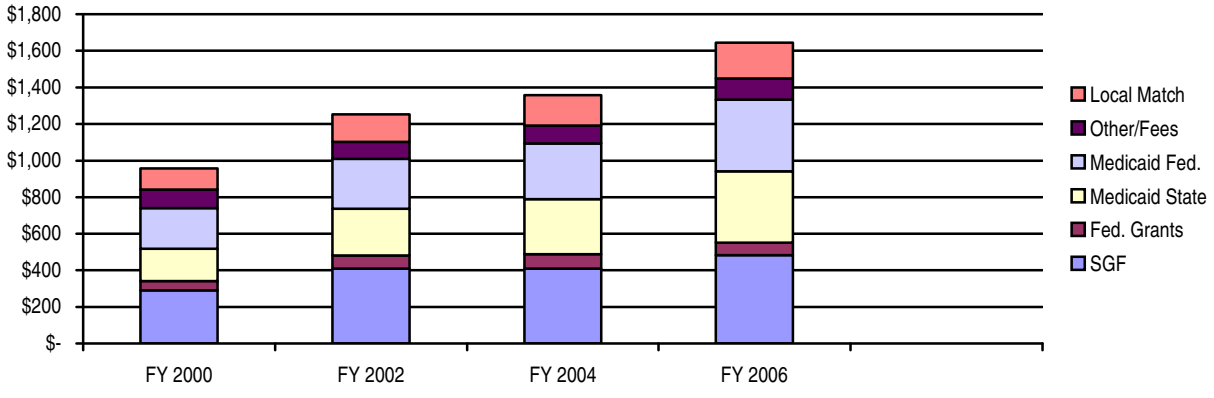


Total Services System Funding Trends

Between FY 2000 and FY 2006, total services system funding grew by 49 percent from $1,106.3 million to $1,644.8 million. The following table depicts funding by source (in millions) for this time period.

Total Services System Funds by Source
FY 2000 – FY 2006

	FY 2000	FY 2002	FY 2004	FY 2006
State General Funds	399.9	408.2	408.7	482.4
Federal Grants	56.2	72.2	78.7	68.5
Medicaid - State	209.0	256.9	302.1	390.9
Medicaid - Federal	223.2	273.3	303.7	390.9
Other/Fees	102.0	92.8	99.0	115.8
Local Match	115.9	149.3	166.2	196.2
Total	$1,106.3	$1,252.7	$1,358.4	$1,644.8



Dollars in charts and table above are in millions

III. DESCRIPTIONS OF POPULATIONS SERVED AND PREVALENCE ESTIMATES

Individuals Who Have a Serious Mental Illness or Serious Emotional Disturbance

A mental disorder is broadly defined in the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition* (the *DSM* IV) as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment of one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.

Mental disorders are common. The annual prevalence of these disorders is nearly 20 percent, and the lifetime prevalence of all mental disorders in the general population is 20-25 percent. Only a portion of individuals with diagnosable disorders will need services at any given time and an even smaller portion will require or seek services from the public sector.

There have been many significant advances in the treatment of mental illness, to the extent that today, there are many effective treatments for most mental disorders. In addition to emergency services that are available to any individual in crisis, Virginia's public services system provides services to adults who have serious mental illnesses and children who have or are at risk of having serious emotional disturbance.

Serious Mental Illness means a severe and persistent mental or emotional disorder that seriously impairs the functioning of adults, 18 years or age or older, in such primary aspects of daily living as personal relations, self-care skills, living arrangements, or employment. Individuals with serious mental illness who also have been diagnosed as having a substance use disorder or mental retardation are included in this definition. Serious mental illness is defined along three dimensions: diagnosis, level of disability, and duration of illness. All three dimensions must be met to meet the criteria for serious mental illness.

- Diagnosis: an individual must have a major mental disorder diagnosed under the *Diagnostic and Statistical Manual of Mental Disorders* (DSM IV, Fourth Edition). These disorders are: schizophrenia, major affective disorders, paranoia, organic or other psychotic disorders, personality disorders, or other disorders that may lead to chronic disability.
- Level of Disability: There must be evidence of severe and recurrent disability resulting from mental illness that must result in functional limitations in major life activities. Individuals should meet at least two of the following criteria on a continuing or intermittent basis.
    a. Is unemployed or employed in a sheltered setting or a supportive work situation, has markedly limited or reduced employment skills, or has a poor employment history.
    b. Requires public financial assistance to remain in the community and may be unable to procure such assistance without help.
    c. Has difficulty establishing or maintaining a personal social support system.
    d. Requires assistance in basic living skills such as personal hygiene, food preparation, or money management.
    e. Exhibits inappropriate behavior that often results in intervention by the mental health or judicial system.
- Duration of Illness: The individual is expected to require services of an extended duration, or his treatment history meets at least one of the following criteria.
    a. The individual has undergone psychiatric treatment more intensive than outpatient care, such as crisis response services, alternative home care, partial hospitalization, or inpatient hospitalization, more than once in his or her lifetime.
    b. The individual has experienced an episode of continuous, supportive residential care,

other than hospitalization, for a period long enough to have significantly disrupted the normal living situation.

Substance use disorders frequently occur in conjunction with serious mental illness.

Serious Emotional Disturbance means a serious mental health problem that affects a child, age birth through 17, and can be diagnosed under the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* or meets specific functional criteria.

- Problems in personality development and social functioning that have been exhibited over at least one year's time,
- Problems that are significantly disabling based on social functioning of most children of the child's age,
- Problems that have become more disabling over time, and
- Service needs that require significant intervention by more than one agency.

Substance use disorders frequently occur in conjunction with serious emotional disturbance.

Children "At-Risk" of Serious Emotional Disturbance means a condition experienced by a child, age birth through 7, which meets at least one of the following criteria:

- The child exhibits behavior or maturity is significantly different from most children of the child's age, and is not due to developmental disability or mental retardation, or
- Parents or persons responsible for the child's care have predisposing factors themselves, such as inadequate parenting skills, substance use disorder, mental illness, or other emotional difficulties, that could result in the child developing serious emotional or behavior problems, or
- The child has experienced physical or psychological stressors, such as living in poverty, parental neglect, or physical or emotional abuse, which put him at risk for serious emotional or behavior problems.

Individuals Who Have an Intellectual Disability (Mental Retardation)

Mental retardation, as defined in the *Code of Virginia*, means a disability originating before the age of 18 years that is characterized concurrently by (i) significantly sub-average intellectual functioning as demonstrated by performance on a standardized measure of intellectual functioning, administered in conformity with accepted professional practice, that is at least two standard deviations below the mean and (ii) significant limitations in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. With each individual, limitations often co-exist with strengths. With appropriate personalized supports over a sustained period, the life functioning of individuals with mental retardation generally will improve; however, mental retardation is a life-long disability.

The American Association on Intellectual and Developmental Disabilities (AAIDD), formerly the American Association on Mental Retardation or AAMR, has adopted the term "intellectual disability" in place of "mental retardation."

Individuals Who Have a Substance-Use Disorder

Substance use disorders (SUDs) are types of mental disorders that are "related to the taking of a drug of abuse (including alcohol), to the side effects of a medication, and to toxin exposure" (DSM IV, Fourth Edition). There are two levels of substance use disorders: substance addiction (dependence) or substance abuse.

- Substance addiction (dependence), as defined by ICD-9, means uncontrollable substance-seeking behavior involving compulsive use of high doses of one or more substances resulting in substantial impairment of functioning and health. Tolerance and withdrawal are

characteristics associated with dependence. Dependence is a maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following occurring at any time in the same 12-month period.

1. Needing markedly increased amounts of the substance to achieve intoxification or a desired effect or having a markedly diminished effect with continued use of the same
2. Having the characteristic withdrawal syndrome for the substance or the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms;
3. Taking larger amounts of the substance or over a longer period than was intended;
4. Having a persistent desire or unsuccessful efforts to cut down or control substance use;
5. Spending a great deal of time on activities necessary to obtain the substance, use the substance, or recover from its effects;
6. Giving up or reducing important social, occupational, or recreational activities because of substance use; and
7. Continuing substance use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

- Substance abuse as defined by ICD-9, means a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances. It leads to clinically significant impairment or distress, as manifested by one (or more) of the following occurring within a 12-month period:
  1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household);
  2. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);
  3. Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct); and
  4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxification, physical fights).

Prevalence Estimates

When planning for Virginia's future public mental health, mental retardation, and substance abuse services system, it is important to have a sense of how many individuals might seek care from the services system. This section uses national epidemiological studies as the basis for extrapolating Virginia prevalence rates for adults with serious mental illnesses, children and adolescents with serious emotional disturbances, individuals with mental retardation, and individuals with substance use disorders. Prevalence is the total number of cases within a year. This differs from incidence, which is the number of new cases within a year. Total population prevalence estimates are based on the 2005 Estimated Population data from the Weldon Cooper Center for Public Service at the University of Virginia.

Estimated Prevalence for Adults with Serious Mental Illnesses: An estimate of the number of adults over age of 18 with serious mental illnesses was developed using the methodology published by the U.S. Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA) in the Federal Register, Volume 64, No. 121, Thursday, June 24, 1999. This methodology, which estimates that 5.4 percent of the state's resident population has a serious mental illness, was applied to the 2005 Estimated Population data to estimate that 308,037adults in Virginia have a serious mental illness.

Estimated Prevalence for Children and Adolescents With Serious Emotional Disturbance: An estimate of the number of children and adolescents ages 9 through 17 with serious emotional disturbances was developed using the methodology published by the U.S. Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA) in the Federal Register, Volume 63, No. 137, Friday, July 17, 1998. These prevalence rates were applied to the 2005 Estimated Population data to estimate that between 84,923 and 103,794 children and adolescents in Virginia have a serious emotional disturbance (level of functioning score of 60). Between 47,179 and 66,051 have serious emotional disturbance with extreme impairment (level of functioning score of 50).

Estimated Prevalence for Individuals with Intellectual Disabilities (Mental Retardation) and Individuals in Need of Early Intervention Services: The prevalence rate nationally for individuals with intellectual disabilities is between 1 and 3 percent (Arc of the United States, October 2004). A conservative estimate (using the 1 percent rate and the 2005 Estimated Population data) indicates that 69,470 Virginians age 6 and over have an intellectual disability.

The prevalence rate nationally for children born with birth defects is between 3 and 5 percent of children born annually. Using national and Virginia studies of children with specific diagnoses selected by Virginia, estimates of children with delay influenced by Virginia poverty rates, prevalence of low birth weight children, children identified on hearing registry; children assessed and requiring services in one year, and rates of states with comparable eligibility, the Department estimates that 3 percent of Virginia's infants and toddlers are potentially eligible for Part C services. These studies include: *Estimating Service Needs: An Epidemiological Approac*h (OSEP Technical Assistance Document, 2000), *Virginia Congenital Anomalies Reporting and Education System, Birth Defects Surveillance Data 1989-1998* (Virginia Department of Health, 2003), *Analysis of Part C Individual Child Data for 1998-2002, Final Report* (Old Dominion University, 2003), *State and Jurisdictional Eligibility Definitions for Infants and Toddlers with Disabilities Under IDEA* (NECTAC Notes, Issue 11, 2005), *A First Look at the Characteristics of Children and Families Entering Early Intervention, September 27, 2002, National Early Intervention Longitudinal Study* (U.S. Department of Education Data Analysis System, 2004), and the Virginia Cost Study 2004 (Solutions Counseling Group). The 3 percent estimated rate was applied to Virginia's population, using 2005 Estimated Population data to estimate that 18,622 Virginia infants and toddlers need early intervention services.

Estimated Prevalence for Individuals with Substance Use Disorders: Prevalence estimates of substance abuse and dependence in the past year for individuals who are age 12 and over were obtained from the 2004 and 2005 National Household Surveys on Drug Use and Health (NSDUH). Using 2005 Estimated Population data, estimated prevalence of adults and adolescents reporting past year dependence or abuse of alcohol or other drugs follows:

- Dependence on or abuse of any illicit drug – 2.76 percent or 174,865 Virginians are dependent on or abuse illicit drugs. An estimated 119,744 Virginians, or 1.89 percent of the total population, met the criterion for dependence.
- Dependence on or abuse of alcohol – 7.38 percent or 467,573 Virginians are dependent on or abuse alcohol. An estimated 209,711 Virginians, or 3.31 percent of the total population met the criterion for dependence.

Appendix D contains prevalence estimates for serious mental illness, serious emotional disturbance, intellectual disability (mental retardation), and drug and alcohol dependence by CSB.

IV. CURRENT AND FUTURE SERVICE NEEDS

CSB Waiting Lists

The following table displays the number of individuals who were on CSB waiting lists for community mental health, mental retardation, or substance abuse services during the first four months of 2007.

Numbers of Individuals on CSB Waiting Lists for Mental Health, Mental Retardation, or Substance Abuse Services: January - April 2007

Populations of CSB Waiting Lists	Numbers Who ARE Receiving Some CSB Services	Numbers Who Are NOT Receiving Any CSB Services	Total Numbers on CSB Waiting Lists
CSB Mental Health Waiting List Count			
Adults with a Serious Mental Illnesses	3,418	611	4,029
Children and Adolescents With or At Risk of Serious Emotional Disturbance	1,224	456	1,680
Total MH	4,642	1,067	5,709
CSB Mental Retardation Waiting List Count			
Individuals on CSB Waiting Lists for MR Waiver and Non-Waiver Services	4,852	1,114	5,966
CSB Substance Abuse Waiting List Count			
Adults with Substance Use Disorders	1,565	616	2,181
Adolescents with Substance Use Disorders	144	90	234
Total SA	1,709	706	2,415
Total CSB Mental Health, Mental Retardation, or Substance Abuse Services Waiting List Count			
Grand Total on All CSB Waiting Lists	11,203	2,887	14,090

During the time period during which the CSB mental retardation waiting lists were completed, 1,745 persons on these lists also were on the MR waiver urgent waiting list, 1,617 were on the waiver non-urgent list, and 569 were on CSB waiver planning lists.

To be included on the waiting list for CSB services, an individual had to have sought the service and been assessed by the CSB as needing that service. CSB staff also reviewed their active cases to identify individuals on their active caseloads who were not receiving all of the amounts or types of services that they needed. This point-in-time methodology for documenting unmet service demand is conservative because it does not identify the number of persons who needed services over the course of a year.

Appendix E depicts numbers of individuals on waiting lists for mental health, mental retardation, and substance abuse services by CSB.

Diagnostic information and special conditions and risk factors of individuals on waiting lists for CSB mental health, mental retardation or substance abuse services follow.

Numbers of Individuals on CSB Mental Health Services Waiting Lists

Diagnostic Information
January – April 2007

Diagnosis	Adult	C&A	Diagnosis	Adult	C&A
Serious Mental Illness (SMI)	2,761		Co-occurring MI/MR	123	35
Serious Emotional Disturbance (SED)		1,135	Co-occurring MI/MR/SUD	18	1
Any Other MI Diagnosis	498		Developmental Disability (Not MR)	45	26
Any Other ED or MI Diagnosis		281	Not Known at This Time	315	262
Co-occurring MI/SUD	910	59			

Special Conditions or Risk Factors
January – April 2007

Special Condition or Risk Factor	Adult	C&A
Deafness or Hearing Loss	67	8
Blindness or Visual Impairment	78	12
Non-ambulatory or Major Difficulty in Ambulation	139	3
Unable to Communicate with Verbal Speech	23	12
Traumatic Brain Injury	94	12
Dementia	87	
High or Extensive Behavioral Challenges	688	704
High or Extensive Physical or Personal Care Needs	336	53
Concurrent Major Medical Condition or Chronic Health Problem	1,152	51
Limited English Proficiency (National Origin)	106	23
At Risk of Being Homeless or Out or Home Placement	736	316
Current Residence Is Not Satisfactory or Appropriate to Individual's Needs	462	98
Current Residence Is Satisfactory But Supports Provided are Inadequate	510	335
Currently Unemployed or No Day Support Options	1,783	
Receiving Special Education		472
Currently Truant, Expelled, Suspended, or School Drop Out		167
Social Supports Are Limited or Lacking	2,020	625
Aging Care Giver	186	105
Care Giver Illness or Disability	74	
Care Giver Is Unable or Unwilling to Provide Support		127
No Guardian or Legally Authorized Representative	194	6
Family Has Petitioned to be Relieved of Custody to Receive Services		8
Aging Out of CSA or Foster Care Financing for Residential Services		21
Social Services/Juvenile Justice System Involvement		362
In Jail, Correctional Facility, or Criminal Justice Involvement	287	
Lacks Transportation	1,073	130
No Special Conditions or Risk Factors	241	135
Special Conditions or Risk Factors Not Known at This Time	493	280

Numbers of Individuals on CSB Mental Retardation Services Waiting Lists

Diagnostic Information
January – April 2007

Diagnosis	Total	Diagnosis	Total
Mental Retardation	4,960	Co-occurring MR/MI/SUD	29
Cognitive Developmental Delay	331	Autism	486
At Risk for Cognitive Developmental Delay	33	Developmental Disability (Not MR or Autism)	235
Co-occurring MR/MI	616	Not Known at This Time	65
Co-occurring MR/SUD	14		

Special Conditions or Risk Factors
January – April 2007

Special Condition or Risk Factor	Individuals
Deafness or Hearing Loss	241
Blindness or Visual Impairment	389
Non-ambulatory or Major Difficulty in Ambulation	758
Unable to Communicate with Verbal Speech	1,178
Traumatic Brain Injury	79
Dementia	29
High or Extensive Behavioral Challenges	1,263
High or Extensive Physical or Personal Care Needs	1,090
Concurrent Major Medical Condition or Chronic Health Problem	1,068
Limited English Proficiency (National Origin)	133
At Risk of Being Homeless	253
Current Residence Is Not Satisfactory or Appropriate to Individual's Needs	278
Current Residence Is Satisfactory But Supports Provided are Inadequate	1,658
Currently Unemployed or No Day Support Options	623
Social Supports Are Limited or Lacking	1,689
Aging Care Giver (Caregiver is 55 or older)	1,338
Care Giver Illness or Disability	883
Family Has Petitioned to be Relieved of Custody to Receive Services	19
No Guardian or Legally Authorized Representative	1,071
An Application for Training Center Placement Has Been Initiated	6
Aging Out of CSA or Foster Care Financing for Residential Services	76
Aging Out of Special Education	659
In Jail, Correctional Facility, Juvenile Detention Facility, or Criminal Justice Involvement	33
Lacks Transportation	910
No Special Conditions or Risk Factors	467
Special Conditions or Risk Factors Not Known at This Time	370

Numbers of Individuals on CSB Substance Abuse Services Waiting Lists

Diagnostic Information
January – April 2007

Diagnosis	Adult	Adol.	Diagnosis	Adult	Adol.
Substance Dependence	1,166	68	Co-occurring SUD/MR	12	1
Substance Abuse	433	84	Co-occurring SUD/MI/MR	5	0
Any Other SA Diagnosis	170	11	Developmental Disability (Not MR)	14	3
Co-occurring SUD/MI	680	97	Not Known at This Time	261	27

Special Conditions or Risk Factors
January – April 2007

Special Condition or Risk Factor	Adult	Adolescents
Deafness or Hearing Loss	5	0
Blindness or Visual Impairment	8	1
Non-ambulatory or Major Difficulty in Ambulation	25	0
Unable to Communicate with Verbal Speech	2	0
Traumatic Brain Injury	33	1
Dementia	6	
High or Extensive Behavioral Challenges	244	84
High or Extensive Physical or Personal Care Needs	68	6
Concurrent Major Medical Condition or Chronic Health Problem	279	7
Limited English Proficiency (National Origin)	55	4
At Risk of Being Homeless or Out or Home Placement	405	34
Current Residence Is Not Satisfactory or Appropriate to Individual's Needs	184	30
Current Residence Is Satisfactory But Supports Provided are Inadequate	168	42
Currently Unemployed	838	
Currently Truant, Expelled, Suspended, or School Drop Out		63
Social Supports Are Limited or Lacking	774	90
Aging Care Giver	21	7
Care Giver Is Unable or Unwilling to Provide Support	18	23
Family Has Petitioned to be Relieved of Custody to Receive Services		2
Aging Out of CSA or Foster Care Financing for Residential Services		5
Currently Pregnant	21	1
Female who Currently Resides with Dependent Children	203	
IV Drug Use	150	0
In Jail, Correctional Facility, or Criminal Justice Involvement	776	
Department of Social Services/Juvenile Justice System Involvement		138
Lacks Transportation	624	14
No Special Conditions or Risk Factors	189	13
Special Conditions or Risk Factors Not Known at This Time	392	25

The following table depicts the length of time that individuals were reported to be on CSB mental health, mental retardation, or substance abuse services waiting lists.

Length of Time on CSB Waiting Lists for All Services
January – April 2007

	Mental Health		Mental Retardation	Substance Abuse		Total
	Adult	C & A		Adult	Adolescent	
Under 1 Month	112	23	199	41	4	379
1 to 3 Months	2,686	1,319	683	1,544	157	6,389
4 to 12 Months	886	272	905	467	59	2,588
13 to 24 Months	214	45	920	81	12	1,272
25 to 36 Months	66	9	768	26	2	871
37 to 48 Months	19	4	524	8	0	555
49 to 60 Months	19	3	417	4	0	443
61 to 72 Months	11	0	321	2	0	334
73+ Months	16	5	1,229	8	0	1,259
Not Reported	1	0	28	7	0	36
Total	4,030	1,680	5,994	2,181	334	14,126

Other Indicators of Community-Based Services Needs

In addition to individuals on waiting lists for CSB mental health, mental retardation, or substance abuse services, there are additional disability-specific, community-based service needs that are significant and compelling.

- Virginia Department of Education counts made on December 1, 2006, identify 11,621 students with a primary disability (as defined by special education law) of emotional disturbance and 10,986 students with mental retardation who are receiving special education services. As these students age out of special education services, many will require community-based treatment or habilitation services to maintain the skills they learned in special education. Virginia schools are presently serving 7,910 children under the age of six who are diagnosed with a developmental disability and 583 children under the age of six with Autism Spectrum Disorder.

- In August 2007, there were 3,791 individuals on the Statewide Waiting List for MR Waiver Services (1,931 on the urgent needs wait list and 1,860 on the non-urgent needs wait list). While over 1,354 community slots have been allocated since 2004, over 1,500 new names have been added to the urgent needs list alone. This means that the urgent needs component of the waiting list has been growing at a rate greater than one individual per day.

- In January 2006, communities across Virginia participated in a statewide one-day point-in-time count and found over 9,600 homeless persons. The count found 2,000 individuals (21 percent of all persons who were homeless) had been homeless for a year or longer or had been homeless at least three times in the previous four years and also had a disabling condition (i.e., meeting the HUD definition of chronic homelessness).

- CSBs serve a large number of infants and toddlers in programs funded through the Part C program. In 2006, 10,704 infants, toddlers, and their families were served, indicating that the trend will continue upward for the number of children served in 2007, due in part to better outreach and case finding. The current data system allows for reporting the number

of children in the system by annualized count (December 2-December 1, one-year period) and by point-in-time (December 1 of each year). The annualized count provides a much more accurate picture of the total number of children served.

- The 2003 National Survey on Drug Use and Health estimated that, nationwide, 9.8 percent of pregnant women drank alcohol during their pregnancy and 4.3 percent of pregnant women used an illicit drug. Of the 104,488 infants born in Virginia in 2005, it is estimated that 10,234 were exposed to alcohol in utero and 4,492 to an illicit substance.
- The 2005 National Survey on Drug Use and Health estimates that there are 136,000 Virginians needing but not receiving treatment for illicit drug use in the past year and 422,000 needing but not receiving treatment for alcohol use in the past year. Patterns of drug use reflect an increased prevalence of prescription drug and methamphetamine abuse and dependence.
- According to the 2005 National Survey on Drug Use and Health, among adolescents ages 12 to 17, the rate of illicit drug use in the past year was higher among those who received mental health treatment or counseling in the past year than among those who did not (29.1 vs. 17.2 percent). This pattern was also observed for marijuana, cocaine, heroine, hallucinogens, inhalants, and the nonmedical use of prescription –type psychotherapeutics.
    - Adolescents aged 12 to 17 who received mental health treatment or counseling in the past year were more likely to use alcohol in the past year than those who did not receive treatment or counseling (39.7 vs. 31.5 percent).
    - Adolescents receiving mental health treatment or counseling in the past year also were more likely to have smoked cigarettes in the past year (25.8 vs. 14.9 percent).
    - In 2005, among adolescents who received mental health treatment or counseling in the past year, 14.2 percent were dependent on or abused illicit drugs or alcohol in the past year, higher than the 6.3 percent who did not receive treatment or counseling.

V. CRITICAL ISSUES AND STRATEGIC RESPONSES

A. Transforming Virginia's System of Care

Integrated Strategic Plan for Virginia's Services System

The Department's Integrated Strategic Plan (ISP), *Envision the Possibilities: An Integrated Strategic Plan for Virginia's Mental Health, Mental Retardation, and Substance Abuse Services System*, (2005) continues to provide a framework for transforming Virginia's publicly funded mental health, mental retardation, and substance abuse services system to:

- Fully implement self-determination, empowerment, recovery, resilience, and person-centered core values at all levels of the system through policies and practices that reflect the unique circumstances of individuals with one or more of the following: mental illnesses, mental retardation, or substance abuse disorders.
- Incorporate the principles of inclusion, participation, and partnerships into daily operations at all levels.
- Expand services and supports options needed to support individual and family choice, community integration, and independent living.
- Provide sufficient capacity to meet growing individual needs so that individuals with mental illnesses, mental retardation, or substance use disorders, wherever they live in Virginia:
  - Receive the levels of services and supports they need,
  - When and where they need them,
  - In appropriate amounts, and
  - For appropriate durations.
- Promote the health of individuals receiving services, families, and communities.
- Increase opportunities for collaboration among state and community agencies.
- Align administrative, funding, and organizational processes to make it easier for individuals and families to obtain the services and supports they need.
- Monitor performance and measure outcomes to demonstrate that services and supports are appropriate and effective, promote services system improvement, and consistently report on the transformation process.
- Provide stewardship and wise use of system resources, including funding, human resources, and capital infrastructure, to assure that services and supports are delivered in a manner that is efficient, cost-effective, and consistent with evidence-based and best practices.

Vision for the Future Services System in Virginia

The Department is committed to implementing the vision "of a consumer-driven system of services and supports that promotes self-determination, empowerment, recovery, resilience, health, and the highest possible level of individual participation in all aspects of community life, including work, school, family and other meaningful relationships" (State Board Policy 1036 (SYS) 05-3).

Services and Supports Principles and Practices

Individuals with mental illnesses, intellectual disabilities, or substance use disorders are members of the community in which they live and should enjoy the same opportunities for quality of life. The overarching goal of the services system is to provide or assist individuals in obtaining services and supports based on informed choice that would enable them to:

- Attain their highest achievable level of health and wellness;
- Live as independently as possible, with children living with their families;
- Engage in meaningful activities, including school attendance or work in jobs that they have chosen; and
- Participate in community, social, recreational, and educational activities.

Consumer and Family Member Participation: Consumers and family members must be actively involved in all aspects of service planning, implementation, and monitoring and must be afforded multiple opportunities to participate in planning and policy development activities at the state and community levels. The perceptions and life experiences of consumers and family members also are important drivers for system transformation activities, particularly in areas such as:

- Overcoming stigma and advancing public awareness of the many contributions and successes of individuals with disabilities; and
- Promoting and supporting self-advocacy and individual wellness, growth and development.

In 2006, the State Mental Health, Mental Retardation and Substance Abuse Services Board adopted Policy 1040 (SYS) 06-3 Consumer and Family Member Involvement and Participation. This policy articulates the importance of consumer and family member involvement and participation and identifies ways in which the Department, state facilities, and CSBs can support the involvement and participation of consumers and family members as partners in the design, operation, and evaluation of the public services system. Activities identified in the policy include:

- Analyzing, formulation, and implementing policies;
- Planning services and designing programs;
- Providing direct services;
- Advocating for resources and fulfilling unmet needs for services;
- Monitoring and evaluating services, providers, and the services system; and
- Providing accountability and engaging in quality improvement activities.

The policy calls on the Department, state facilities, and CSBs to support consumer and family involvement and participation on committees, work groups, task forces, and other planning or deliberative bodies. It encourages CSBs to work closely with the boards of supervisors or city councils and county administrators or city managers of their local governments to help them appoint consumers and family members who are knowledgeable about the services system to community services boards.

Services and Supports Values: The ISP identifies the following values as underpinning the design and operation of services and supports:

- Services and supports are person-centered. Individuals receiving services and family members have access to information, are involved in service planning, and have decision-making power over the types of services and supports they need and use. The specific needs of each individual are at the center of service planning and care coordination.
- The services system is designed to intervene early to minimize crises through early screening and assessment, appropriate interventions that keep individuals receiving services connected to their families and natural supports, and seamless access to services.
- Services and supports are available and delivered as close as possible to an individual's home community and in the least restrictive setting possible, are culturally and age sensitive and appropriate, and are fully integrated and coordinated with other community services.

- Adults and children requiring services and supports from multiple agencies are provided care that is coordinated across agencies.
- Services and supports are flexible, allow for the greatest amount of individual choice possible, and provide an array of acceptable options to meet a range of individual needs.
- A consistent minimum level of types and amounts of services and supports is available across the system, with timely access to needed services.
- Prevention, early intervention, and family support services are critical components of the services system.
- Services are universally and equally accessible regardless of the individual's payment source.
- Services are of the highest possible quality and are based upon best and promising practices, where such practices exist.
- Services are provided in an efficient and cost-effective manner to enhance service quality and continuity of care and to take advantage of technologies that provide appropriate access to properly protected information.
- Emphasis is placed on continuous quality improvement at the provider and system levels, with performance and outcome measures focused on self-determination, empowerment, recovery, resilience, and community integration.
- Integrated and flexible public funding of mental health, mental retardation, and substance abuse services promotes person-centered and recovery-oriented service and supports.
- Public funding is adequate to meet individual needs and includes cost inflators to sustain capacity and address the total costs of service delivery.
- The services system is committed to state facility and community workforce training, retraining, development, retention, and expansion to needed staffing levels.

Wide Front Door: The ISP envisions Virginia's services system as having a wide "front door" for screening and assessing the needs of individuals who seek publicly funded mental health, mental retardation, or substance abuse services or supports. It states that referrals to this "front door" should come directly to the CSB or through referrals to CSBs from local hospital emergency rooms or other local agencies. All individuals and families seeking services and supports should receive timely and thorough initial screening and state-of-the-art assessments provided by well-qualified and highly trained staff. Assessment results should determine the types, levels, and amounts of needed services and supports depending upon the complexity of the individual's condition or his level of functioning.

Following assessment, services and supports choices should be identified for each individual. These choices should be flexible and provided as close to the individual's home and natural supports as possible. Regardless of where an individual lives in Virginia, individuals and their families should have access to a broad array of services and supports that promote independence and enable individuals to live in their own homes or natural environments wherever possible, and when not possible, with other family members.

Collective Responsibility for and Flexible Implementation of Safety Net Services: The ISP describes the public safety net and serves as the conceptual basis for State Board Policy 1038 (SYS) 05-5 The Safety Net of Public Services. This policy states that the Department and CSBs, as partners in the mental health, mental retardation, and substance abuse service system, are jointly responsible for assuring to the greatest extent practicable the provision of a safety net of appropriate public services and supports in safe and secure settings for individuals with serious mental illnesses, mental retardation, substance use disorders, or co-occurring disorders who:

- Are in crisis or have severe or complex conditions;

- Cannot otherwise access needed services and supports because of their level of disability, their inability to care for themselves, or their need for a highly structured or secure environment; and
- Are uninsured, under-insured, or otherwise economically unable to access appropriate service providers or alternatives.

The policy directs that public safety net services shall be available to the greatest extent possible on a 24 hours per day and seven days a week basis within clinically reasonable time periods to anyone who needs them. It identifies the following as safety net services: local emergency services, in-home assistance and support or out-of-home respite care, non-hospital based crisis stabilization or detoxification services, acute stabilization in local psychiatric or substance abuse inpatient or medical detoxification services, and specialty services provided in state facilities or a regional or statewide basis. The policy defines the public safety net to include services delivered by private inpatient and community service providers under contract to CSBs or state facilities. It also affirms the responsibility of CSBs to serve as the single points of entry into the safety net of public services, to screen and assess individuals, and to manage and review access to and utilization of public safety net services.

The policy states that the specific array or extent of public safety need services may differ among localities, and individual programs may reflect differences in design and operation. However, it asserts that some services, such as emergency or crisis stabilization services, should be provided as close to a person's home and natural supports as possible. When these local services are not available or appropriate or more specialized or intensive services are needed, the policy directs CSBs or the Department with the responsibility for assuring the availability of these safety net services on a sub-regional, regional, or statewide basis.

Services and Supports Reflect the Core Values of Self-Determination, Recovery, Resilience, and Person-Centered Planning. The ISP calls for the expansion of recovery and resilience-oriented and person-centered services, training, and supports provided by and for peers and families, including:

- Individual and family education and support,
- Services provided by peer specialists,
- Family resource centers,
- Individual wellness recovery planning, and
- Peer-run programs such as peer-to-peer drop-in centers.

Every locality would have the capacity to provide, either locally or through regional arrangements, crisis access and response 24 hours per day and seven days a week. Crisis access and response services include:

- Locally provided emergency services;
- In-home assistance to stabilize a crisis;
- Non-hospital crisis stabilization and detoxification; and
- Acute stabilization in local hospitals.

Access to and continuation in the most intensive services would be rigorously screened and continuously reviewed to assure services are provided in the most integrated and least intrusive setting appropriate to the acuity and complexity of the individual's condition or his level of functioning. Referrals to emergency and crisis services would be immediate. Referrals to non-emergency services provided by the CSBs, peer-run organizations, local agencies, or other providers would be within a reasonable period of time based on individual need. Services utilization, including hospitalization, would be managed by the CSBs in collaboration with other providers, as appropriate, for the period suitable to the needs of the individual.

At the local level, CSBs would provide, directly or through contracts with other community providers, the following core array of recovery and resilience-oriented and person-centered services:

- Prevention and early intervention services,
- Infant and toddler intervention,
- Respite care,
- In-home services, including intensive in-home therapy by licensed clinicians,
- Care coordination and case management,
- Medication and medication education services,
- Outpatient treatment provided by trained clinicians using best and promising practices,
- Integrated treatment for persons with co-occurring MI/SUD, MI/MR, or MR/SUD diagnoses,
- Supported employment and vocational training,
- Rehabilitation and day support services,
- Day treatment provided in schools or clinics,
- Supervised and supportive residential services, and
- Intensive community treatment, training, and transitional services.

In addition, a system of care for children and adolescents would be available. This system of care would include cross-agency planning and coordination at the local level with child-serving agencies and the Comprehensive Services Act teams; with family involvement; respite care services; family supports; behavioral health support for schools, court services, health departments, and social services; and early intervention services through local schools, behavioral health, and other health care clinics.

While it is preferable in most instances to provide services and supports in an individual's home community, there may be situations where needed services are beyond the capacity of most localities to provide. These services and supports would be provided at the regional level through specialized teams, regional programs, or utilization of emerging technologies such as teletherapy or teleconsultation. These services and supports may include:

- Regional MR/MI behavioral consultation teams;
- Regional MI/SUD consultation teams;
- Expert consultation teams for nursing homes and assisted living facilities; and
- Specialty clinical services (e.g., extensive assessments for medical and psychiatric needs, child and family therapy, and medical and dental supports).

The following specialty services would be available statewide or at the regional level.

- Intermediate treatment and rehabilitation and intensive treatment for individuals with severe or complex conditions, or both, requiring care in state hospitals;
- Intensive short-term acute inpatient crisis intervention, stabilization, and treatment for children and adolescents with high acuity or high complexity behavioral health conditions, or both;
- Intensive medical (to include skilled nursing), behavioral, or other specialized supervision and therapeutic interventions for individuals with mental retardation;
- Secure forensic and not guilty by reason of insanity (NGRI) services; and
- Behavioral rehabilitation services for sexually violent predators.

In 2006, the State Board adopted Policy 1039 (SYS) 06-2 Availability of Minimum Core Services. This policy recognizes the importance of intervening early to minimize crises through early screening and assessment; delivering services and supports that are appropriate and age and culturally sensitive as close to the individual's home community as possible; and providing a

consistent minimum level of services and supports with timely access to needed services across Virginia. The policy defines the minimum array of services and supports as follows:

- Minimum safety net services, as described in State Board Policy 1038;
- Outpatient treatment services, including intensive in-home services, medication and medication education services, and assertive community treatment;
- Case management and care coordination;
- Day treatment provided in schools or other sites and rehabilitation services;
- Supported employment services;
- Supervised residential services, including in-home respite care, and supportive residential services, including respite care;
- Prevention and early intervention, including infant and toddler services; and
- Services managed and provided by consumers, including peer-to-peer drop-in centers, individual wellness recovery planning, peer-run programs, family resource centers, and consumer and family member education and support.

The ISP states that funding should follow the individual and not a specific provider or service. Integrated funding, with cost of living escalators, would reduce existing funding complexity and provide flexibility needed to create choices among services and supports that promote self-determination and person-centered planning, empowerment, recovery, and resilience for individuals receiving services.

Critical Success Factors

Seven critical success factors described below are required to transform the current services system's "crisis-response" orientation to one that provides incentives and rewards for implementing the vision of a recovery and resilience-oriented and person-centered system of services and supports. Successful achievement of these critical success factors will require the support and collective ownership of all system stakeholders.

1. Virginia successfully implements a recovery and resilience-oriented and person-centered system of services and supports.
2. Publicly funded services and supports that meet growing mental health, mental retardation, and substance abuse services needs are available and accessible across Virginia.
3. Funding incentives and practices support and sustain quality care focused on individuals receiving services and supports, promote innovation, and assure efficiency and cost-effectiveness.
4. State facility and community infrastructure and technology efficiently and appropriately meet the needs of individuals receiving services and supports.
5. A competent and well-trained mental health, mental retardation, and substance abuse services system workforce provides needed services and supports.
6. Effective service delivery and utilization management assures that individuals and their families receive services and supports that are appropriate to their needs.
7. Services and supports meet the highest standards of quality and accountability.

Implementation of the Governor's Transformation Initiative

In late 2005, Governor Warner proposed and incoming Governor Kaine supported a multi-year plan to transform Virginia's mental health, mental retardation, and substance abuse services system through:

- Investment in community services and supports to reduce state facility utilization, and

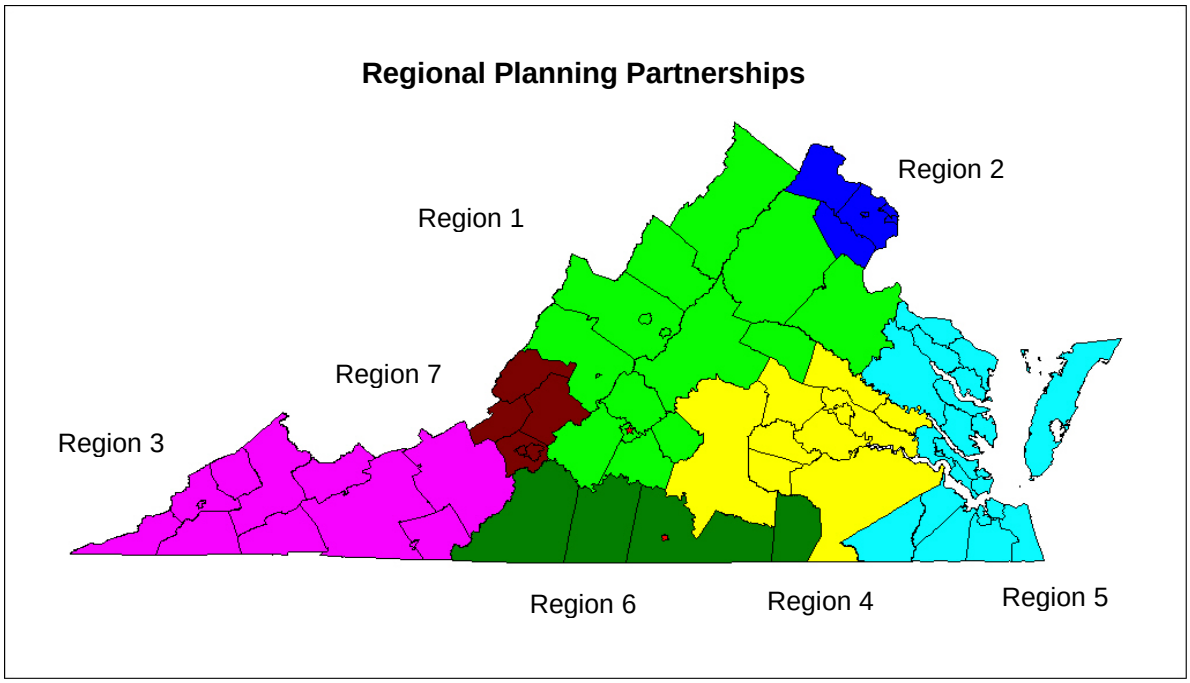
- Redesign and replacement of two state hospitals (Eastern State Hospital and Western State Hospital) and two training centers (Southeastern Virginia Training Center and Central Virginia Training Center) to address current and future clinical needs more efficiently and appropriately.

During the 2006 session, the General Assembly amended, expanded, and approved the Governor's Transformation Initiative. This initiative represents an historic opportunity to make a positive difference in the lives of individuals with serious mental illnesses, co-occurring mental illnesses and substance use disorders, or mental retardation who receive publicly-funded services and supports.

For the 2006-2008 biennium, the Transformation Initiative provided just over $187.5 million in state general and Medicaid funds for a wide array of community investments, including:

- Expansion of community mental health services, including:
  - recovery and peer supports, including consumer-operated services and programs, consumer peer specialists and recovery coaches, recovery education and training, consumer stipends and employment and training scholarships, and deaf peer support;
  - community crisis stabilization, including in-home and residential crisis stabilization and diversion
  - crisis response and referral services, including outpatient crisis response and crisis intervention teams, regional flexible funding for regional crisis services and mobile crisis team stipends, expanded crisis staff, clinicians with co-occurring expertise, and crisis prevention services;
  - psychiatric services, including expanded psychiatric time, psychiatric nursing, medical consultation, and psychiatric support services;
  - intensive case management and hospital liaison services,
  - residential services, and
  - forensic and jail-based services;
- Funding for new discharge assistance plans for civil and not guilty by reason of insanity patients currently in state facilities;
- Funding to provide mental health services for children and adolescents in six additional juvenile detention centers and through two new systems of care projects;
- Investments in community mental health services associated with the redesign and replacement of Eastern State Hospital and Western State Hospital;
- MR waiver rate increases; expansion of waiver slots, including 214 slots for individuals on the waiver's urgent waiting list, 110 slots for children under the age of six, and 149 slots for Southeastern Virginia Training Center and Central Virginia Training Center residents; and provision of waiver start-up funds;
- Support for mental retardation guardianship services for training center residents or individuals who are at risk of training center placement;
- Expansion of Part C early intervention services for infants and toddlers; and
- Funding for substance abuse opiate treatment and jail diversion services.

The seven Regional Planning Partnerships are coordinating implementation of community services and supports funded through the Transformation Initiative. With guidance provided by the Department that focused on implementing the Vision and values of recovery, resilience, self-determination, person-centered planning, and community integration, each Regional Planning Partnership established services and supports priorities that were tailored to that region's needs. The Partnerships provide quarterly implementation progress reports to the Department.



Implementation of Community Adult MH and MH/SA Services:

The following table provides a listing of individuals who have received community-based services through the Transformation Initiative.

Community Adult Mental Health and Co-Occurring MI/SA Services

Service	# Served in FY 2007	Service	# Served in FY 2007
Emergency Services	1,956	Individual Support Employment	16
Acute Psychiatric Inpatient Services	41	Highly Intensive Residential	34
Community-Based SA Medical Detox Inpatient Services	655	Residential Crisis Stabilization Services	939
Outpatient Services	4,246	Intensive Residential Services	203
Peer-Provided Outpatient Services	51	Supervised Residential Services	89
Opioid Detoxification Services	6	Supportive Residential Services	277
Case Management Services	3,059	Peer-Provided Supportive Residential Services	76
Peer-Provided Case Management Services	51	Consumer Monitoring	15
Day Treatment/Partial Hospitalization	50	Discharge Assistance Project Plans	114
Ambulatory Crisis Stabilization Services	10	Consumer-Run Services	637
Rehabilitation	326	Totals	13,074
Peer-Provided Rehabilitation	223		

Implementation of Child/Adolescent Services

Systems of Care Demonstration Projects: Four systems of care demonstration projects are providing an array of services, including evidence-based practices, to children and adolescents throughout Virginia. These projects were first funded in FY 2006 (Richmond Behavioral Health Authority and Planning District 1) and later in FY 2007 (Alexandria and Cumberland Mountain). In FY 2007, 194 children and adolescents had been referred and 84 enrolled and were receiving services. For 53 children and adolescents, the treatment team, the consumer and their family have agreed to end services because desired clinical outcomes had been achieved.

Juvenile Detention Center Services: Programs are operational and ongoing in 14 juvenile detention centers. In each program, CSBs have placed clinical and case management staff on-site in the center. Services provided include screening and assessment, short-term treatment, case management and referral to community-based services. In FY 2007, of the 2,209 youth admitted to juvenile detention centers, 2,060 received mental health screening and assessment during detention center intake, 808 youth received case management services, 814 received individual face-to-face therapy, 16 were admitted to state hospitals, and 394 were released to community with an aftercare plan for individual face-to-face therapy.

Part C Early Intervention Services: All appropriated funds were allocated to local early intervention systems (local lead agencies) for Virginia's Part C Early Intervention System for infants and toddlers with disabilities. In FY 2007, 5,559 new children, ages 0-3 were served in the part C system. A total of 10,408 children were served during the fiscal year.

Implementation of Community MR Services

Community Integration: During FY 2007, 115 community MR waiver slots have been assigned to individuals on the Urgent Wait List. Additionally, 24 slots were used by Central Virginia Training Center and 10 slots were used by Southeastern Virginia Training Center to support development of community-based services for residents or individuals that would have been admitted without these resources. Slightly more than $200,000 of community capacity funds has been distributed to 72 individuals placed by the CSBs through use of the slots made available in 2007. In addition to these services, community capacity funding has been used to:

- Establish one full year of training in the College of Direct Support for providers of community Waiver services to enhance the skills and qualifications of the direct care staff,
- Train and endorse an additional 25 in individuals in the southwestern region of Virginia in Positive Behavioral Supports adding to the number of qualified behavior therapists in the community.
- Provide funds for assessment and intensive support needs for individuals engaging in high-risk behavior in southeastern Virginia who are at risk of institutional placement.

Waiver Services for Children Who Are Under Age 6: All 110 MR waiver slots for children were on the urgent needs wait list were distributed in July of 2006 and services have been initiated. The majority of these slots support consumer directed services, enabling families to hire and train individuals to provide respite and personal assistance services to their children. MR waiver services include in-home residential support, skilled nursing, and assistive technology and environmental modifications.

MR Waiver Rate Increases: Waiver reimbursement rates for congregate residential services increased 10 percent with other selected services increasing 5 percent. A survey by the Virginia Network of Private Providers indicated that a significant portion of these increases was used for direct care salaries and benefits, which contributed significantly to the sustainability of these services. The MR System Study, completed in September 2007, indicated that rate adjustments in other Waiver services would enhance flexibility and improve quality of care.

Guardianship: The Department entered into an agreement with the Virginia Department of Aging to develop public guardianship services for persons living in state training centers and persons living in the community who have need of public guardianship services and contracts were given to five public guardianship organizations statewide. In FY 2007, 83 individuals living in a training center and 122 individuals living in the community were assigned a public guardianship organization. All individuals have either completed the court procedure establishing guardianship services or are still involved in that process. In addition, funds of up to $750 per individual were made available to more than 130 individuals to be used to help pay for the costs associated with petitioning the courts for guardianship.

Implementation of Targeted Jail-Based Services

Transformation funds are supporting seven post-booking diversion services for persons involved in the local criminal justice system. All programs have convened or are convening community stakeholder planning and implementation groups. Five programs have completed memorandums of agreement. In FY 2007, 60 jail inmates have been diverted and 439 inmates have received mental health services. A total of 5,983 hours of intensive case management services were provided. The Department estimates these programs have resulted in estimated savings of $1.2-2.5 million dollars in jail hospital bed day expenses.

Implementation of Opiate Addiction Services

The Department has initiated Buprenorphine Projects in Norfolk and Cumberland Mountain. The Norfolk Project started providing services in March. The Cumberland Mountain Project hired all staff for the Project REMOTE and Substance Abuse Medically-Assisted Treatment in January 2007. In FY 2007, approximately 100 consumers had received services supported by state Substance Abuse Medically-Assisted Treatment funds and 41 consumers had been served through Project REMOTE. Also, nine training sessions for southwest Virginia physicians, nurse practitioners, law enforcement, and pharmacists on the Virginia Prescription Drug Monitoring Program were held with an additional seven training sessions scheduled for 2008.

Status of State Facility Redesigns and Replacements

The Transformation Initiative included funds to rebuild Eastern State Hospital, which is in process, and planning funds for the replacement of Western State Hospital, Southeastern Virginia Training Center, and Central Virginia Training Center. Two proposals for the development of a new Western State Hospital are currently under review. Planning for the two training centers and associated census reductions have not progressed as quickly as initially projected. Factors contributing to delays include:

- The severities of disabilities of persons considering community placements have made it difficult to find appropriate community services for these individuals;
- The wide ranging views among stakeholders regarding the future of the training centers, ranging from strong support for the continuation of training centers at current bed capacities by families of residents to advocacy resistance to rebuilding training centers at any size;
- Strong family resistance to moving family members from training centers; and
- Prohibitive cost estimates for the complete replacement of the training centers.

A wide variety and number of stakeholders are engaged in the training center replacement planning process. These efforts are resulting in a greater consensus on improvements, including continued investment in community services development incentives, development of community ICF/MRs and waiver homes, and training center renovation rather than replacement.

Recently, the Department has been actively involved in developing ways to expand person-centered practices in state facility and community settings. These efforts have been further

emphasized by the Inspector General's study recommendations, the collaborative work of multiple partners involved in the Centers for Medicare and Medicaid (CMS) Systems Transformation Grant, and the General Assembly-mandated MR System Study. This work has involved the exploration of needed training, resources, and systems changes to make person-centered practices the norm in Virginia.

Additionally, an upcoming major effort involves the recently awarded CMS Money Follows the Person demonstration grant, for which the Department is collaborating with multiple agencies. The goals of this five-year project are to rebalance Virginia's long-term support system, giving individuals more informed choices and options about where they live and receive services, and to support the transition of individuals from institutions to community-based alternatives. This project also promotes quality supports through person-centered practices.

Goals, Objectives, and Action Steps

Goal 1: Implement a recovery and resilience-oriented and person-centered system of services and supports.

Objectives:

1. Create awareness and understanding of recovery and resilience-oriented and person-centered principles and practices.

Action Steps:

a. Implement an educational campaign to increase awareness of key policymakers, state and local government officials, individuals and family members, public and private providers, and the general public.

b. Support peer-to-provider training and other learning opportunities for staff of the Department's central office, state facilities, and licensed public and private providers on how they might align their organizational cultures with the vision and services values.

c. Implement a variety of training opportunities designed to increase the knowledge and skills of staff at all levels of state facilities and community provider organizations in implementing recovery, resilience, and person-centered principles and practices.

2. Publicize the commitment of services system leaders to recovery and resilience-oriented and person-centered principles and practices.

Action Steps:

a. Work with CSBs and state facilities to identify and celebrate successful implementation of recovery and resilience-oriented and person-centered practices.

b. Provide State Board and executive recognition of individuals and organizations for their contributions to advancing the vision of the future services system in Virginia.

3. Implement policies and regulations, incentives, service structures, and practices to support implementation of a recovery and resilience-oriented and person-centered system of care.

Action Steps:

a. Incorporate recovery and resilience-oriented and person-centered principles in the revision of the Department's human rights and licensing regulations.

b. Incorporate person-centered principles into policy, practices, and the proposed revisions to the MR home and community-based waiver and day support waiver regulations.

c. Support efforts to develop and disseminate new knowledge on how to implement recovery, resilience, and self-determination principles in state facility and CSB settings.

d. Involve the Department's central office staff, state facilities, CSBs, and other public and private providers in an examination of how current practices for managing risk affect self-determination, empowerment, recovery, resilience, and person-centered practices.

e. Assess the extent to which the minimum core services identified in State Board Policy 1039 are accessible in each CSB service area and work with CSBs to develop strategies for addressing gaps in their minimum core service capacity.

4. Fully implement the Governor's Transformation Initiative.

Action Steps:

a. Work with each Regional Planning Partnership to assure active involvement of consumers, family members, private providers, and other stakeholders in planning, implementing, and monitoring new services and supports funded through the Transformation Initiative.

b. Bring planned community mental health, mental retardation, and substance abuse services on line in a timely manner.

c. Complete capital planning for the redesign of Western State Hospital, Central Virginia Training Center, and Southeastern Virginia Training Center.

d. With funding availability, construct new replacement facilities or redesign and modify existing facilities to better address current and future clinical needs more efficiently and appropriately.

B. Implementation of Self-Advocacy, Self-Determination, Recovery, Resilience, and Person-Centered Principles and Practices

Mental Health

Virginia's mental health system has been enhanced and improved through the involvement of well-informed individuals with mental illnesses or with or at risk of a serious emotional disturbance and their families. Such involvement at all levels of the services system has been and continues to be a priority of the Department. Federal Mental Health Block Grant funds are used to support numerous activities across the state to educate individuals and their families about mental illnesses and treatments. These activities have been accomplished through the following contracts.

Organization	Description	Funding	
		FY 2007	FY 2008
Virginia Human Services Training Center	The Center, located at the Piedmont Virginia Community College with support from Region Ten CSB, trains individuals receiving services as peer counselors. This training is a collaborative effort of the Department, CSBs, the Department of Rehabilitation Services, and the community college. Communities nominate individuals to be trained in the skills needed to provide peer counseling at their home CSBs. Approximately 15 individuals are trained annually.	$74,928	$75,000
Mental Health America – Virginia (MHAV)	MHAV, formerly the Mental Health Association of Virginia, provides Consumer Empowerment Leadership Training (CELT) in all regions across Virginia. This includes specialized training in the skills needed to effectively represent services recipient issues on boards and committees.	$100,000	$100,000

Organization	Description	Funding	
		FY 2007	FY 2008
National Alliance for the Mentally Ill (NAMI)-Virginia	NAMI-Virginia assesses family education needs and provides statewide education about mental illnesses and their treatments to individuals and their families. Over 28 new or existing family education groups have been developed or supported. Technical assistance was provided to 50 family education and support groups using programs such as Mutual Education, Support and Advocacy (MESA), NAMI's Family-to-Family, and NAMI Texas' VISIONS	$50,000	$50,000
Virginia Organization of Consumers Asserting Leadership (VOCAL)	VOCAL is building a strong peer community across the state. VOCAL initiatives include: ➢ Providing technical assistance to peer-run programs	$62,718	$62,718
	➢ Wellness Recovery Action Plan (WRAP) training (Reach Initiative), providing, and building a new statewide peer network.	$55,000	$55,000
	➢ Building and strengthening a new statewide peer network (Consumer Network)	$75,000	$75,000
Peer-Run Programs	These include peer-operated programs and centers, which are located across the State	$261,518	$985,427
Virginia Federation of Families for Children's Mental Health (VAFOF)	VAFOF educates and supports parents and caregivers of children with behavioral health problems through a variety of activities, including workshops and annual conferences that provide information about the services system and teach skills to effectively access services. A Family Leadership train-the-trainer workshop trained family members in the skills needed to conduct their own Family Involvement Workshop. A toll-free telephone number provides information and referral for parents and caregivers. Quarterly newsletters also are published and distributed across Virginia.	$700,000	$700,000
Southwest Virginia Consumer and Family Involvement Project	This peer-driven project prepares individuals with mental illness to become meaningfully involved in the mental health system by providing education, advocacy, and support. Project activities focus on increasing individual and family participation in decision-making and policy formation, in service planning, and in the delivery and evaluation of publicly funded mental health services. Activities include the coordination of LEAP (Leadership-Empowerment-Advocacy Program) Training, MESA Training, Peer Counselor Training, and Community Integration Groups.	$42,500	$42,500
Family Support Services Project in Southwest Virginia	The project is directed to family members of persons with serious mental illness and involves close collaboration with CSBs in the southwest region and the Southwestern Virginia Mental Health Institute. The project develops and assists family support groups with education, support, and advocacy. Project activities include implementation of a toll-free information and referral line and "Ask the Doctor" videoconferences between support groups and the Institute	$32,500	$32,500

In addition to these initiatives, when one-time funds are available, the Department works with the Virginia Mental Health Planning Council to support other projects that promote individual and family involvement and education.

The Department has continued to support individual involvement in the annual meetings of the Virginia chapter of the United States Psychiatric Rehabilitation Association (formerly IAPSRS).

Individuals from across the state are able to attend the annual meeting and learn about innovative services and opportunities to expand their involvement in transforming the services system.

Mental Retardation

Involvement by individuals receiving services and their families is a critical component of all mental retardation services supported through the Department and the Department provides technical assistance to all providers in principles and practices of person-centered planning. This includes individual and family involvement in the development of their case management and Medicaid Waiver plans, agreement to these plans, and participation in the annual planning process for services.

Individuals receiving services and their families also are involved in a number of policy and planning processes. All Part C workgroups and administrative committees include family members, and the Virginia Interagency Coordinating Council, the oversight committee appointed by the Governor, has several family members. The Mental Retardation Waiver Advisory Council and the Advisory Consortium on Intellectual Disabilities (TACID) include self-advocates and family members of community and facility residents. These councils and the Person-Centered Planning (PCP) Leadership Team provide direction and offer input on the future direction of services for persons with intellectual disabilities in Virginia.

The Department is involved in two multi-agency, multi-year projects, the Centers for Medicare and Medicaid Services (CMS) funded Systems Transformation Grant and the Money Follows the Person Demonstration grant. Each project has a Leadership Team composed of up to 51 percent self advocates and family members. A Person Centered Practices Leadership Team, headed by the Department, provides input into the Systems Transformation Grant and the MR System Study workgroup. An important subgroup of this larger team is a group of self-advocates who are advising the full team on larger systems issues and directions.

Since 2003, the Department has been involved in New Voices, a grant funded by the Virginia Board for People with Disabilities (VBPD), which assists individuals with developmental disabilities in Virginia to become self-advocates and assume greater roles in deciding their futures. At least one participant is a lifelong resident of a training center who is seeking to live in the community. In 2004, the VBPD approved funding for a community inclusion grant through which the Department oversees a process of awarding smaller mini-grants to agencies and providers around the state who have developed innovative ideas that use existing systems and resources to promote greater community inclusion opportunities for individuals with disabilities.

Each year, all CSBs give family satisfaction surveys to families of people with mental retardation receiving case management services. Families return the surveys directly to the Department and results are analyzed to determine individual or family member perceptions of services. Results are shared with each CSB.

Substance Abuse

Individual advocacy for substance abuse services has been slow to develop due to stigma, shame, and fear. Initially organized in 1997 as a grassroots advocacy organization, the Substance Abuse and Addiction Recovery Alliance (SAARA) of Virginia continues to make strong inroads in Virginia by establishing and supporting local affiliates. Now incorporated as a 501c3 nonprofit organization, SAARA's mission is to maximize "the power of the people to advocate for treatment and recovery in order to prevent the harmful effects of substance abuse upon families, businesses, and the community." Its membership is open to individuals and organizations.

SAARA's goals include informing the public about the impact of addictions and the resources and services available for treatment and prevention; developing and sustaining SAARA as a viable organization; communicating with the general public and legislative bodies; and becoming fiscally self-sustaining. SAARA and the Virginia Federation of Families have partnered to develop family support and advocacy for youth who have a substance use or co-occurring disorder and their families. As a part of its goal to become self-sustaining, its board of directors has received training in fund raising and is implementing strategies to encourage corporate memberships. SAARA publishes a quarterly newsletter, *The Recovery Advocate*, has established a website (www.saara.org), and conducts an annual conference for members and interested persons.

Goals, Objectives, and Action Steps

Goal 2: Increase opportunities for individual and family involvement.

Objective:

1. Maintain current avenues for individual and family representation, while seeking to widen the scope of individual involvement in all aspects of the mental health system.

Action Steps:

a. Continue to strengthen the voice of the Mental Health Planning Council in mental health services development and in implementation and monitoring of the Transformation Initiative.

b. Provide funding to support individual and family involvement in restructuring and re-investment planning processes and meetings.

c. Seek ways to build and link the network of parents of children and adolescents with mental health, mental retardation, and substance abuse service needs.

d. Promote and expand LEAP and the CELT Leadership Academy training to better prepare individuals and family members for meaningful roles in planning and policy making activities.

e. Keep VOCAL and peer-run programs throughout Virginia fully informed about opportunities to be involved in system initiatives and activities.

Goal 3: Improve opportunities for individual and family education and training.

Objective:

1. Increase the number of individuals and family members who receive training.

Action Steps:

a. Continue to fund a statewide recovery and peer-to-peer education program run by and for individuals receiving mental health services and supports.

b. Contract with NAMI, VOCAL, VAFOF, MHAV, VHST, and other peer-run projects to provide education and training (e.g., REACH, CELT, and LEAP).

c. Promote and expand the evidence-based practice of family psycho-education (e.g. MESA and NAMI's Family-to-Family program).

d. Promote opportunities for CSBs to support consumer and family education and training (e.g., providing scholarships to recovery conferences and training events).

e. Increase the accessibility of the "Navigating the MR Waiver" workbook and training module for families through the website and encourage case managers to distribute these documents to family members.

Goal 4: Promote and support the implementation of mental health programs that foster empowerment, peer support, and recovery-based services.

Objectives:

1. Collaborate with the Mental Health Planning Council and other system partners to transform the current system of services and supports toward a recovery orientation.

Action Steps:

a. Target Mental Health Block Grant dollars to support transformation activities.

b. Explore the feasibility of incorporating recovery-oriented evidence-based practices of illness self-management, assertive community treatment, and supported employment as Medicaid-covered services through the Real Choice System Transformation grant.

2. Promote the establishment and expansion of peer-run programs across Virginia.

Action Steps:

a. Continue to enhance and strengthen Virginia's statewide network of peer organizations and family alliances.

b. Develop new and expand existing peer-run centers and support the establishment of peer-run programs in each CSB service area.

c. Explore opportunities for addressing the recovery issues of older adolescents through peer-to-per services and peer-to-provider training.

d. Continue to fund and support a statewide network of local peer organizations that increase the voice and representation of individuals receiving services and supports.

e. Support the development of consumer-run self-help groups for persons with co-occurring disorders, including but not limited to, Double Trouble in Recovery.

Goal 5: Provide individuals and families with the opportunity, at the systems and individual levels, to determine the types of mental retardation services and supports they receive and to evaluate the quality of those services.

Objectives:

1. Expand the number of individuals receiving services and families involved in the planning process.

Action Steps:

a. Conduct TACID meetings in multiple areas of the state in order to facilitate participation from self-advocates and family members who would otherwise be unable to attend.

b. Increase the number of self-advocates acting in an advisory capacity to the Department via participation in groups such as TACID, the PCP Leadership Team, and the MR Waiver Advisory Committee.

c. Promote individual and family involvement in the PCP Leadership Team and the MR Waiver Study through the payment of stipends to these representatives.

d. Support the "New Voices" project to develop more direct input and understanding of the messages from individuals with mental retardation.

e. Schedule a minimum of three focus groups annually, inviting individuals and families who represent different types of issues, e.g., access to supported employment services or supporting family members with a dual diagnosis.

f. Continue training opportunities for provider and agency staff that include developing person-centered environments for individuals and their families.

2. Assure greater opportunities for individual and family direction in their own services.

Action Steps:

a. Continue to work with DMAS to obtain federal approval for self-directed waiver services and expand opportunities for individual and family participation in person-centered services through the MR home and community-based and day support waivers.

b. Implement a planning process in the mental retardation MR waiver that is person-centered and promotes improved quality of life.
c. Develop, in collaboration with potential users, materials that better enable individuals with intellectual disabilities to guide their own services.
d. Determine the satisfaction of families and individuals who receive services through a survey method.

Goal 6: Reduce the stigma and shame associated with substance use disorders that inhibit people from seeking help and restrict resources that support treatment and prevention.

Objectives:

***1. Facilitate the development and growth of the Substance Abuse and Addiction Recovery Alliance (SAARA) as a fiscally independent organization with a strong, viable membership*.**

Action Steps:

a. Partner with SAARA to develop and implement initiatives that will educate members of the general public as well as targeted groups, such as family members and physicians, about substance use disorders and evidence-based treatment.
b. Continue to contract with SAARA to develop individually oriented products and services that foster advocacy in the community.
c. Continue to provide technical assistance to SAARA by utilizing national and federal resources.
d. Continue to support SAARA in pursuing and developing sustainable fiscal resources.

2. Support Virginia Federation of Families efforts to develop and expand their services to include families who have a youth with a substance use or co-occurring substance use and mental health disorder.

Action Steps:

a. Partner with the VAFOF in developing and implementing initiatives that educate members of the general public and targeted groups, such as family members and physicians, about substance use disorders and evidence-based treatment for youth.
b. Encourage and support a partnership between VAFOF and SAARA to develop a coordinated approach to serving families affected by substance use.
c. Provide technical assistance to VAFOF by utilizing national and federal resources.

C. Access to Services and Supports That Meet Individual Needs

Olmstead Decision Implementation Update

In 1999, the United States Supreme Court issued a decision in the case of Olmstead v. L.C., 119 S. Ct. 2176 (1999). This case involved a challenge under Title II of the Americans With Disabilities Act (ADA), 42 U.S.C. § 12132, by two women with mental disabilities who lived in mental health facilities operated by the state of Georgia, but who wished to live in the community. The ADA prohibits discrimination in public services furnished by governmental entities (Title II, 42 U.S.C. § 12131-12165). Title II regulations issued by the U. S. Attorney General include an integration regulation stating: "A public entity shall administer services, programs and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." The most integrated setting is that which enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible. The U.S. Supreme Court held that Georgia had violated the ADA by forcing these women to remain in a

state mental hospital after their treating professionals had determined that they were ready for discharge.

In the decision, the Court held that a state is required under Title II of the ADA to provide community-based treatment for persons with mental disabilities when:

- The state's treatment professionals determine that such placement is appropriate;
- The affected persons do not oppose such placement; and
- The placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others with disabilities.

Although the Olmstead case involved two individuals with a mental disability, the decision is broad in its scope and applies to all qualified persons with disabilities covered by the ADA. It applies to all qualified individuals with mental, physical, or sensory disabilities. It applies to individuals who are institutionalized or who are at risk of institutionalization.

The Olmstead decision does not prohibit institutional placement, but, in fact, recognizes it as the least restrictive setting for some individuals who cannot handle or benefit from community settings. Additionally, the decision affirms that there is no federal requirement that imposes community-based treatment of patients who do not desire it.

States must make reasonable accommodations in programs in order to provide community-based services to qualified individuals, unless doing so would fundamentally alter the services provided. This "fundamental alteration" standard is met if the state can demonstrate that it has:

- A comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and
- A waiting list that moves at a reasonable pace not controlled by the state's efforts to keep its institutions fully populated.

State Implementation Team: The Department continues to take an active leadership role in the Commonwealth's efforts to advance opportunities for maximum community integration for people with disabilities. The Department's Assistant Commissioner for Community Services is a member on the State Implementation Team, now composed of 22 state agencies, four Secretariats, and two Councils. The Team continues to have lead responsibility for developing an integrated plan for Virginia that advances community integration opportunities. The importance of this initiative to the Executive Branch was underscored by Governor Kaine's issuance of Executive Order 2 on his first day in office, January 14, 2006.

Implementation Updates: The *Third Annual Implementation Team Report to the Oversight Advisory Board* (Board) was submitted in July 2006, pursuant to Executive Order 2. The Team made similar reports in both 2004 (EO 61) and 2005 (EO 84). The Team worked collaboratively with agency staff and the 21-member stakeholder Board to develop Virginia's first *Cross-Governmental Strategic Plan to Assure Continued Integration of Virginians with Disabilities into the Community.*

The *2007 Update and Progress Report* (August 2007) specifies the following goals, developed from the Vision statement within the Olmstead Task Force Report.

1. Virginians with disabilities who currently reside in a state mental health, mental retardation, nursing or assisted living facility will have the opportunity to choose to move from these facilities to an appropriate, more integrated setting and stay there.
2. Virginians with disabilities who are at risk of unwanted admission to a state mental health, mental retardation, nursing or assisted living facility, will have the opportunity to receive services and supports that prevent admission.

The vision of community integration will be realized only when people with disabilities can achieve the following goals:

- Plan, fully understand and choose among services and supports they need, self-directing them to the extent possible;
- Choose among individuals and agencies qualified to provide the services and supports they select;
- Locate and obtain housing appropriate to their needs and preferences;
- Locate and obtain a job, if appropriate;
- Access transportation appropriate to their needs;
- If they lack capacity to make decisions, have the same choices, options and benefits as other Virginians with disabilities through a surrogate decision-maker qualified to act on their behalf; and
- Access ongoing supports in order to stay in the most integrated setting of choice, self-directing them to the extent possible.

Implementation of these important goals requires the ongoing collaboration of Secretariats, agencies and Councils represented on the Team. The Team will continue to work with the Community Integration Advisory Commission in the coming years to continue to move Virginia forward.

Recent Department Actions in Support of Olmstead:

- The Governor and 2006 General Assembly strongly supported a transformation initiative that is expanding community-based mental health, mental retardation, and substance abuse services by providing targeted funding increases to CSBs.
- As directed by the General Assembly, the Department, DMAS, the VACSB, the ARC of Virginia, and other stakeholders have jointly reviewed the MR services system to determine how it could be improved to provide a person-centered, individualized support focus. Study recommendations center on improving service access, quality, and responsiveness.
- The Choice in Consumer Living Grant, awarded to the Department by the Virginia Board for People with Disabilities (VBPD) is a unique practice model that supports individuals moving from institutions to the community. The Department awarded and, at the request of the CSB, has since canceled a sub-grant to Region Ten CSB, which was looking at several innovative residential options for individuals moving out of state training centers. A sub-grant has also been awarded to Community Opportunities, Inc. in Southwest Virginia, which is working on the role of circles of support in guardianship and decision-making for transition to community living.
- A subcommittee of the Mental Health Planning Council has developed white papers on the evidence-based practices of Illness Management and Recovery and Supported Employment. These papers included background and recommendations for implementation in Virginia.
- Through a Positive Behavioral Supports (PBS) II grant from VBPD to the Partnership for People with Disabilities, a PBS curriculum was developed and established within a university for course credit. This grant supported the formation of an Endorsement Board with a mentoring and portfolio development process that can be reimbursed under the MR waiver. This grant has achieved sustainability, as the Department invested an additional $200,000 over the next year and the Department for Rehabilitative Services is considering further investments in the area of Brain Injury Services.
- Services are being provided at two new MR Regional Community Support Centers at Central Virginia Training Center and Southwestern Training Center. Demand continues to grow and state facility directors and recipients alike are pleased with the progress.

- The Department continues to contract with Mental Health America - Virginia to provide Consumer Empowerment Leadership Training (CELT) to Virginians with mental illness. Three events per year are currently conducted.
- The Department is involved in two multi-agency, multi-year projects, the CMS-funded Systems Transformation Grant and the Money Follows the Person demonstration grant. The intent of these projects is to give individuals more informed choices and options about where they live and receive services and promote the transition of individuals from institutions to community-based alternatives.

Community Services and Supports Capacity Development

Communities lack basic mental health, mental retardation, and substance abuse services capacity to address existing demand and anticipated population growth. The Governor's Transformation Initiative, while significant by Virginia standards, represents an initial commitment of resources needed to realize the goals established by the President's New Freedom Commission and Virginia's *Cross-Governmental Strategic Plan to Assure Continued Integration of Virginians with Disabilities into the Community*.

Virginia Tech Tragedy Underscores Services Gaps: The deadliest mass shooting on a university campus took place on April 16, 2007 at Virginia Polytechnic Institute and State University (Virginia Tech) in Blacksburg. Twenty-seven students and five teachers were killed and 29 persons were injured. The accused shooter, a fourth year student at Virginia Tech, committed suicide. In December 2005, this individual was the subject of a temporary detention order (TDO) and had been committed to outpatient psychiatric treatment. Following the TDO, he received minimal treatment.

Although the tragedy at Virginia Tech is an aberration, it underscored the need for immediate action to resolve service capacity issues that are endemic across Virginia. In response to this tragedy, the Office of the Inspector General (OIG) conducted an on-site investigation of services provided by the local CSB, psychiatric unit of a local hospital, assessment by the independent evaluator and services of the VA Tech counseling center in connection with a December 2005 temporary detention order and judicial commitment process. To address basic access issues identified during the investigation, the OIG recommended that:

- The number and capacity of secure crisis stabilization programs be expanded statewide in order to address the challenges frequently faced by prescreeners in securing a willing temporary detention facility in a timely manner;
- The capacity of outpatient treatment services, including outpatient counseling or therapy delivered by masters or doctorate level mental health professionals and psychiatric services provided by a psychiatrist, psychiatric nurse practitioner or other medical personnel who deliver a variety of therapeutic interventions and medications, be expanded statewide; and
- The number of CSB case managers be increased in order to decrease caseloads and increase the support provided to those with serious mental illness and those who receive treatment services involuntarily.

The Virginia Tech Review Panel, appointed by Governor Kaine to conduct an independent investigation of the Virginia Tech shooting, issued its report on August 30, 2007. The Panel found mental health services to be inadequate and the lack of sufficient resources has resulted in gaps in the mental health system, including short-term crisis stabilization and comprehensive outpatient services. The Panel's recommendation IV-16 follows: "The number and capacity of secure crisis stabilization units should be expanded where needed in Virginia to ensure that individuals who are subject to a temporary detention order do not need to wait for an available bed. An increase in capacity also will address the use of inpatient beds for moderately to severely ill patient that need longer periods of stabilization." (page 61)

Services Needed by Individuals on CSB Waiting Lists: To document existing service demands, the Department asked the CSBs to complete a point-in-time survey of specific service requirements of each person on CSB waiting lists during the first three months of 2007. The waiting list information only includes those individuals who sought service from a CSB and were assessed by that CSB as needing the service. Therefore, the waiting lists do not capture the number of people who requested services from a CSB, but did not follow through with the assessment process once they learned there was a waiting list for services. Needed services and average service wait times by program area follow. Services are defined in Appendix B.

Numbers of Individuals on CSB Mental Health Services Waiting Lists by Service
January – April 2007

Service	Adult	C&A	Service	Adult	C&A
Outpatient Services					
Psychiatric Services	1,759	561	Intensive SA Outpatient (MI/SA)	271	63
Medication Management	1,519	527	Intensive In-Home		479
Counseling and Psychotherapy	1,681	973	Assertive Community Treatment	315	
Case Management					
Case Management	1,226	556			
Day Support Services					
Day Treatment/Partial Hospitalization	333		Therapeutic Day Treatment		269
Rehabilitation	399	47	Alternative Day Support Arrangements	196	316
Employment Services					
Sheltered Employment	144	10	Individual Supported Employment	413	42
Group Supported Employment	85	14			
Residential Services					
Highly Intensive (MH)	142	40	Supervised	341	36
Highly Intensive (SA Detox)	62	4	Supportive	612	107
Intensive	145	31			
Early/Infant-Toddler Intervention					
Infant and Toddler Intervention		11			

Of the children and adolescents on waiting lists for CSB mental health services, 1,464 were identified by the CSBs as currently needing specific services, 35 were identified as needing specific services beginning the 2010-2012 biennium, and 39 were identified as needing specific services beginning in the 2012-2014 biennium. Of these children and adolescents, 224 were in a Comprehensive Services Act mandated population and 768 were in a non-mandated population. Additionally, as of June 30, 2007, there were 185 individuals in state hospitals whose discharges had been delayed due to extraordinary barriers.

Numbers of Individuals on CSB Mental Retardation Services Waiting Lists by Service
January – April 2007

Service	MR	Service	MR
Outpatient Services			
Psychiatric Services	565	Intensive In-Home (MR/MI)	321
Medication Management	696	Assertive Community Treatment (MR/MI)	23
Behavior Management	756		

Service	MR	Service	MR
Case Management			
Case Management	2,409		
Day Support Services			
Rehabilitation/Habilitation (Center and Non-Center)	664	Alternative Day Support Arrangements	999
Employment Services			
Sheltered Employment/Prevocational	764	Individual Supported Employment	754
Group Supported Employment	624		
Residential Services			
Highly Intensive (ICF/MR or Other Specialized)	340	Supervised (Congregate)	1,082
Intensive (Congregate)	971	Supportive (Supported Living, In-Home, Personal Assistance, Companion Services, Respite)	2,879
Early Intervention			
Infant and Toddler Intervention	61		
Other Services and Supports			
Nursing Services	257	Environmental Modifications	527
Assistive Technology	730	Personal Response System (PERS)	108
Therapeutic Consultation	415		

Of the individuals on waiting lists for CSB mental retardation services, 4,760 were identified by the CSBs as currently needing specific services, 506 were identified as needing specific services beginning the 2010-20012 biennium, and 341 were identified as needing specific services beginning in the 2012-2014 biennium. Of the children and adolescents on waiting lists for CSB mental retardation services, 219 were in a Comprehensive Services Act mandated population and 954 were in a non-mandated population.

On August 1, 2007, there are 140 training center residents who, with their authorized representative or family member, had chosen to be served in a community setting.

Numbers of Individuals on CSB Substance Abuse Services Waiting Lists by SA Service January - April, 2007

Service	Adult	Adol.	Service	Adult	Adol.
Outpatient Services					
Psychiatric Services	585	101	Methadone Detoxification	45	0
Medication Management	488	81	Opioid Replacement Therapy	120	1
Counseling and Psychotherapy	1,068	100	Assertive Community Treatment (MH)	43	
Intensive SA Outpatient	889	60	Intensive In-Home (MH/SA)		22
Case Management					
Case Management	798	52			
Day Support Services					
Day Treatment/Partial Hospitalization	122		Alternative Day Support Arrangements	19	6
Rehabilitation	126	3	Therapeutic Day Treatment		16
Employment Services					
Sheltered Employment	34	1	Individual Supported Employment	130	14

Service	Adult	Adol.	Service	Adult	Adol.
Group Supported Employment	20	2			
Residential Services					
Highly Intensive	210	14	Supervised	150	6
Intensive	283	31	Supportive	93	1
Early Intervention					
Early Intervention		17			

Of the adolescents on waiting lists for CSB substance abuse services, 40 were in a Comprehensive Services Act mandated population and 98 were in a non-mandated population.

Average Wait Times for CSB MH, MR, and SA Services: As part of the waiting list survey, CSBs were asked to estimate the number of weeks individuals waited prior to their actual receipt of specific services. Average wait times across the CSBs for specific services follow.

Average Wait Times in Weeks to Access Services Reported by CSBs
April 2007

Service	MH Services		MR Services		SA Services	
	Adults	C & A	Adults	C &A	Adults	Adoles.
Initial Assessment	3.83	4.33	3.31	4.64	2.97	2.50
Outpatient Services						
Medication Services	6.00	4.68	6.28	5.33	6.24	5.18
Psychiatric Services	6.16	4.95	6.47	5.57	6.45	5.20
Counseling & Psychotherapy	6.52	4.38			2.93	2.97
Behavior Management			18.83	33.00		
Intensive SA Outpatient					2.69	2.44
Intensive In-Home		5.47				
Methadone Detox					3.00	5.00
Opioid Replacement					3.38	5.00
Assertive Community Treatment	10.14					
Case Management Services						
Case Management Services	5.00	3.87	15.47	8.54	2.36	2.33
Day Support Services						
Day Treatment/Partial Hospitalization	1.50				1.75	
Therapeutic Day Treatment (C&A)		5.50				
Rehabilitation/Habilitation	7.00	5.00	67.94	66.29	2.50	2.0
Alternative Day Support Arrangements	0	9.00	41.86	65.20	0	0
Employment Services						
Sheltered Employment	0	0	36.75	52.00	2.00	0
Group Supported Employment	7.00	0	32.78	36.00	3.00	0
Individual Supported Employment	16.43	0	17.18	31.00	4.00	0
Residential Services						
Highly Intensive Residential Services	1.50	0	101.21	53.50	2.00	0

Service	MH Services		MR Services		SA Services	
	Adults	C & A	Adults	C &A	Adults	Adoles.
Intensive Residential Services	39.43	0	106.45	57.33	3.11	2.00
Supervised Residential Services	24.2	0	61.06	58.67	3.00	0
Supportive Residential Services	23.67	4	49.50	43.50	3.00	4.00
Early Intervention/Infant and Toddler Intervention Services						
Early Intervention						2.50
Infant and Toddler Intervention				2.17		
MR Waiver Services						
Nursing Services			7.14	4.20		
Environmental Modifications			22.91	9.00		
Assistive Technology			28.22	20.86		
Personal Response System (PERS)			42.25	4.33		
Therapeutic Consultation			28.38	9.14		

Guardianship: The Department estimates that over 3,000 individuals across Virginia require a guardian or other type of substitute decision-maker in order to facilitate their transition from state facility to community services or to enable them to receive services for which consent is required in community programs. When no substitute decision-maker is available, state facilities and community providers can access the judicial system for court ordered treatment. This alternative provides the required authority for needed treatment, but it does not provide for the participation in decision-making that is necessary for individuals who lack the capacity to participate in other aspects of their care. Court ordered treatment also does not provide for individual choice. When no family member is available to serve as an authorized representative, the state facility or community provider must absorb the cost incurred by pursuing the appointment of a guardian. The average fee for each guardianship proceeding and appointment is $2,500 per year. The Transformation Initiative included $720,000 to provide mental retardation guardianship services for training center residents or individuals who are at risk of training center placement. To date, the Department has received referrals for financial assistance with guardianship services for over 500 individuals with mental retardation.

***Mental Retardation Services System Study*:** Virginia's system of services and supports for individuals with intellectual disabilities comprises a mix of state, local, and federal efforts in a variety of settings. The 2006 General Assembly directed that a collaborative effort between the Department, DMAS, the Virginia Association of Community Services Boards (VACSB), the Arc of Virginia, and other stakeholders, review the current Medicaid MR waiver to determine how the waiver could be improved. The 2007 General Assembly expanded this study to include the entire system of intellectual disability services delivery in Virginia. This study focuses on six areas: behavioral, medical, housing, employment, waiting list, and person-centered planning. Key recommendations to address identified gaps and barriers and increase flexibility and quality follow.

- Reconceptualize plans to replace CVTC and SEVTC and instead re-furbish existing training center buildings and build small 4-bed homes in the community;
- Expand Virginia's investment in the MR waiver to address current waiting lists, ensure the success of the Money Follows the Person initiative, and provide a reserve of slots for crises that emerge during the year;
- Expand family supports and other initiatives that allow individuals to have control over how their service dollars are spent;

- Take regulatory steps to replace the current diagnostic tool for waiver services.
- Address the complex medical needs through creation of a tiered system for skilled nursing, addition of dental as a covered waiver service, changes to the waiver's skilled nursing rate and billing structure, and reimbursement of transportation time;
- Address the needs of individuals who have behavioral challenges through establishment of a psychiatrist position in the central office with a specialty in developmental disabilities and development of tiered reimbursement systems for securing needed behavioral interventions, including behavioral consultation services, mobile special behavioral unit psychiatric and doctoral-level psychologist services, and for residential services;
- Improve housing and residential options through changes to the waiver residential support rate structure, development of a consistent interagency policy to increase the scope of affordable and accessible housing choices, and creation of a bridge subsidy supplement program that covers rent or mortgage costs until HUD subsidy funding becomes available;
- Enhance central office administrative infrastructure to monitor existing services and maintain compliance with CMS expectations and provide cost of living increases for waiver reimbursement rates;
- Improve employment and prevocational opportunities through increased funding for long-term employment support services, adjustments to waiver rates for individual and group supportive employment, change in billing units authorization requirements, clarification of prevocational activities policy, regulatory changes to facilitate self-direction of job coaches, increased earned income allowance, inclusion of employment in discharge planning protocols, facilitation of access to post-secondary transition services, funding to eliminate the "Order of Selection" (waiting list) for DRS vocational services, and amendment of Virginia's Medicaid Buy-in program enable otherwise ineligible individuals to pay a premium to obtain Medicaid coverage;
- Increase the flexibility of the waiver program through addition of nutrition consultation, pharmacy consultation, and ethicist consultation services, allowance of certain environmental modifications and assistive technology to be assessed prior to and in the absence of other waiver services, and clarification in concert with the Board of Nursing services that specifically can or cannot be delegated;
- Promote use of supportive living residential situations through waiver coverage for chore services, caregiver living expenses, housing access coordination, and transportation;
- Provide consistent training for case managers and the direct support workforce through continuation of the web-based College of Direct Support and Positive Behavioral Supports training and endorsement, development of training modules on health and medical management issues, and requirement for training on person-centered practices and state waiver and licensing requirements; and
- Implement a number of strategies to make person-centered practices a reality in Virginia.

***Health Insurance Limitations**:* In addition to basic service capacity needs, the lack of health insurance coverage and parity for the treatment of mental illnesses and substance use disorders forces many persons who would otherwise seek private sector care to rely on the public system for treatment. Although CSBs charge fees based on ability to pay, more expensive modalities, such as residential treatment, are underwritten by tax dollars. The U.S. Census Bureau's Current Population Survey, 2003-2005 Annual Social and Economic Supplements, estimates that the three-year (2002 to 2004) average percentage of Virginians without health insurance coverage is 13.6 percent (90 percent confidence interval of 0.8).

Increasing demands have been placed on the public services system and local hospital emergency rooms as private insurance benefits for behavioral healthcare continue to deteriorate, Medicaid and insurance reimbursement rates fail to cover costs for covered services, and the number of uninsured Virginians seeking behavioral health services continues

to increase. Some private providers are either closing beds or no longer serving publicly funded individuals because third party reimbursement rates do not cover the cost of providing their services. In addition, the overall number of inpatient beds has declined.

Anticipated Changes in the Population Needing Mental Health, Mental Retardation, and Substance Abuse Services: The Department anticipates a variety of factors will converge to increase in the numbers of individuals with mental illnesses, mental retardation, or substance use disorders who will require services in community or state facility settings. These include:

- Increasing services demand resulting from Virginia demographic trends, particularly the continued significant growth in Northern Virginia, Central Virginia, and Eastern Virginia.
- Increasing numbers of older adults in the general population who will require CSB services to enable them to reside in their homes or other community placements;
- Increasing numbers of individuals with co-occurring combinations of mental illnesses, substance abuse disorders, mental retardation or other cognitive deficits; chronic medical conditions, or behavioral challenges who require more complex and specialized interventions and care provided by CSBs or state facilities;
- Evolving needs of consumers who are aging or who have experienced serious medical conditions requiring specialized health services, more complex medication regimes, and ongoing preventive care;
- Increasing pressures on the services system to address limited residential treatment options and decreasing availability of local acute psychiatric beds;
- Growing demand for specialized services reflective of the increasing cultural diversity of Virginia's population;
- Additional demands for specialized services resulting from the aging of current caregivers;
- Increasing numbers of adults and juveniles in the criminal justice system with identified mental illnesses and substance use disorders;
- Increasing numbers of children diagnoses with autism spectrum disorder; and
- Demand for publicly funded services by individuals who have limited or no mental health insurance benefits.

Special Populations Issues

Children and Adolescents Who Have Serious Emotional Disturbances, Cognitive Developmental Delays, or Substance Use Disorders: *Mental Health: A Report of the Surgeon General* cites concerns about inappropriate diagnoses of children's mental health problems. Too often, children with mental health problems do not receive services until they end up in a secure setting such as a hospital, detention center, jail, or a state juvenile correctional facility. The Report identified the following mental disorders with their onset in childhood and adolescence: anxiety disorders, learning and communication disorders, attention-deficit and disruptive behavior disorders, mood disorders (e.g. depressive disorders), autism and other pervasive developmental disorders, eating disorders, tic disorders, and elimination disorders. (*Surgeon General's Report*, 1999) A growing body of empirical evidence estimates a prevalence rate as high as 50 percent for the co-occurrence of alcohol and other drug use among adolescents with mental health disorders. (Petrila, Foster-Johnson, and Greenbaum, 1996)

While progress has been made with system of care initiatives to improve access to services, most notably, the Comprehensive Services Act, Virginia's service system for children continues to be fragmented. There continues to be an over-reliance on residential care and inadequate community services to help parents keep their children at home. Parents are forced to move from agency to agency seeking the coordinated package of services their children need.

The 2004 Appropriation Act included budget language directing the Department and the Department of Medical Assistance Services, in cooperation with the Office of Comprehensive Services, CSBs, and court service units, to develop an integrated policy and plan, including the necessary legislation and budget amendments, to provide and improve access by children and adolescents to mental health, mental retardation and substance abuse services. The Department established the Child and Adolescent Behavioral Health Policy and Planning Committee (CFBHPPC), representing CSBs, state agencies, parents, and other partners to identify service needs and develop the *Policy and Plan to Provide and Improve Access to Mental Health, Mental Retardation and Substance Services for Children, Adolescents and Their Families*. The Appropriation Act requires an annual report to the chairmen of the Senate Finance and House Appropriations Committees. The 2006 report transmitted a 10-year plan for children's behavioral health in Virginia. This plan attempts to achieve three goals:

- Healthy, strong, resilient, stable children and families;
- Equitable access to health and behavioral health services; and
- Humane, least restrictive and effective services that support healthy child development.

The plan outlines broad strategies to meet these goals, activities that carry out the strategies, and measures of outcomes to determine whether the goals have been met. It focuses on the following priority areas:

- Increase service capacity through an expansion of System of Care Demonstration Projects, expanding mental health services in detention facilities, establishing school based mental health services and build the workforce,
- Increase the size of the workforce through funding child psychiatry fellowships and child psychology internships to work in underserved areas in Virginia,
- Establish a university-based teaching center to organize, coordinate and lead the training of clinicians in evidence-based, promising, and best practices for children's behavioral health treatment and to increase the skills of providers who specialize in working with children, and develop competency standards in evidence based treatments,
- Increase statewide family education, information and support to link families with support systems and educate the public about the needs of children with behavioral health problems.

The current *Policy and Plan to Provide and Improve Access to Mental Health, Mental Retardation and Substance Services for Children, Adolescents and Their Families* calls on the Department to adopt children's behavioral health as a very high priority in its policies, plans, and services, to coordinate and plan for children with behavioral health needs with other state agencies, and to provide guidance to help local offices maximize third party funding for children's behavioral health services. The Plan recommends that the Department make prevention activities a central focus of its policies and plans regarding children's behavioral health services, develop case management standards for CSBs throughout the state, and take initial steps to change the term "case management" to "care coordination." Other recommendations focus on:

- Using Comprehensive Services Act funding flexibly and creatively to develop additional services, including pilot projects to serve children with behavioral health needs more effectively at the same or lower cost;
- Suspending rather than ending Medicaid benefits when youth enter detention and prison facilities [Note: Even if Medicaid benefits were suspended, a redetermination of eligibility would be required upon release. DMAS is working with the Department of Juvenile Justice to facilitate transition by starting the Medicaid application prior to a youth's release.]; and
- Expanding the membership of the Child and Family Behavioral Health Policy and Planning Committee in the FY 2007-2008 biennium budget language reauthorizing the Committee.

Older Adults Who Have Mental Illnesses, Mental Retardation, or Substance Use Disorders*:* Nationally, the older adult population accounts for about 12.4 percent of the total population. The anticipated impact of aging "baby boomers" will increase this proportion to 20 percent by 2030. (Federal Interagency Forum on Aging, Korper and Council, 2002) This is likely to place increased pressure on health care services and the demand for social services. Virginia's mental health, mental retardation, and substance abuse services system must plan for the accelerated growth of the older adult population and its proportionately greater and more expensive healthcare needs.

According to *Mental Health: A Report of the Surgeon General* (1999), almost 20 percent of the population 55 and older, or an estimated 337,345 Virginians (2005 Population Estimates), experience specific mental disorders that are not part of "normal" aging. Best estimate one-year prevalence rates for specific mental disorders, based upon epidemiological catchment area information described in the *Surgeon General's Report,* follow.

Estimated One Year Prevalence Rates in Virginia of Mental Disorders Not Associated with Aging

Disorder	Percent	Number	Disorder	Percent	Number
Any Anxiety Disorder	11.4	38,457	Somatization	0.3	1,012
Any Mood Disorder	4.4	14,843	Severe Cognitive Impairment	6.6	22,265
Schizophrenia	0.6	2,024	Any Disorder	19.8	66,794

Mental Health: A Report of the Surgeon General, Chapter 5 Older Adults and Mental Health (page 336), Source of prevalence estimates: D. Regier and W. Narrow, personal communication, 1999.

The *Surgeon General's Report* estimates that an *unmet* need for mental health services may exist for up to 63 percent of adults aged 65 years and older with a mental disorder (p. 341). Also, many elderly individuals need treatment for alcohol and drug abuse disorders and do not receive it; they may be more likely to hide their substance abuse and may be less likely to seek professional help. (CSAT, 1998)

Alcohol and prescription drug misuse and abuse occur among older adults for a variety of reasons. Abuse of alcohol and legal drugs, prescription and over-the-counter, is a serious health problem, affecting up to 17 percent of persons who are 60 or older. Approximately half of older adults are light or moderate drinkers and the interactions between alcohol and other drugs and multiple drug use may result in significant problems for them. (Adams, 1997, CSAT, 1998) Alcohol and drug use may elevate older adults' already high risk for injury, illness, and socioeconomic decline. (Tarter, 1995) Additional drugs are prescribed for more chronic illnesses, and older adults may misuse drugs due to confusion, lack of judgment, or miscommunication. Because of insufficient knowledge, limited research data, and hurried office visits, health care providers tend to overlook substance abuse and prescription drug misuse among older adults, mistaking the symptoms for those of dementia, depression, adverse drug reactions, or other problems common to this population. (Gambert and Katsyoannis, 1995)

Some older adults with mental retardation living in nursing facilities receive case management and other specialized services through OBRA-87 funding. In FY 2008, an estimated 165 individuals will participate in day support or receive needed specialized equipment through this funding source. A challenge for older adults with intellectual disabilities who are living in group homes is to be allowed to retire from work or other day activities, since it is the policy of many such homes that residents remain off-site during the day.

The provision of mental health, mental retardation, and substance abuse services to older adults is complicated by the lack of providers trained to serve this population and the limited number of specialized community-based programs in Virginia. The growing need to better

serve older adults, including those with mental disabilities, represents a shift in this culture's perspective on aging. Where society once assumed that older adults required no more than custodial or end-of-life care, increased longevity; a renewed respect for the social, political, and economic contributions of this population; and the demand for more appropriate treatment choices by individuals who receive services have placed pressures on service delivery systems to develop new treatment models.

Treatment models for older adults with mental illnesses, mental retardation, or substance use disorders must be well coordinated, respond to the unique needs of a population with growing health issues, and provide services that promote new roles for individuals who seek to continue as productive members of their communities. Inpatient geriatric treatment services will not be the answer to the burgeoning geriatric population. The baby boom cohort will be demanding "aging in place" community and home-based services; available resources will need to planned and developed to meet this demand. Services include informed and educated primary care providers equipped to manage and treat minor psychiatric conditions in older adults, short-term respite care that includes psychiatric treatment, assisted living and nursing facilities with integrated psychiatric treatment options, payment systems where the money follows the person, and enhanced availability of program models such as PACE Model programming which allows for the coverage of psychiatric care in the individual's own residence.

Integrating behavioral healthcare into primary care and other generalist settings will benefit older adults with substance use disorders or milder cases of substance dependence. Clearly, a great number of these individuals could be identified through substance screening procedures in primary care or other generalist settings and many could benefit from brief interventions delivered by physicians, nurses, pharmacists, and social workers who interact with them on a regular basis, sometimes in their own homes.

Individuals in the Criminal Justice System Who Have Mental Illnesses, Mental Retardation, or Substance Use Disorders: According to research cited in the President's New Freedom Commission report, about seven percent of all incarcerated individuals have a serious mental illness, a rate that is about three to four times that of the general U.S. population. Those individuals who come into contact with the criminal justice system are often poor, uninsured, disproportionately representative of minority populations, homeless, and living with co-occurring substance use disorders and mental illness. They are likely to continually recycle through the behavioral health and criminal justice systems. When they are incarcerated, these individuals frequently do not receive adequate behavioral health services and have difficulty re-entering and reintegrating into the community after discharge because many of them lose income supports and health insurance benefits. A similar situation exists for youth with serious emotional disturbances who are in the juvenile justice system.

To appropriately address the needs of this population, it is imperative to overcome, to the extent possible, the criminalization of adults with serious mental illnesses and youth with serious emotional disturbances by:

- Fostering the development community-based forensic evaluation and treatment services for those individuals who cannot be diverted from criminal justice system involvement;
- Reducing or eliminating prolonged waits for hospital admission for forensic evaluations and treatment that must be accomplished on an inpatient basis; and
- Defining improved methods for delivering a satisfactory array of psychiatric and substance abuse treatment in jails and detention centers.

Behavioral health services for individuals involved in Virginia's criminal justice system should be a community-focused endeavor, whenever possible. While there will always be a subgroup of jail residents who will require acute inpatient treatment, many inmates with mental health or

substance use disorders can be served on-site in-jail settings, provided that the necessary and appropriate services and supports are available in these locations.

State Board Policy 1041 (SYS) 06-4 Services for Individuals with Mental Illnesses, Mental Retardation, or Substance Use Disorders Who Are or Are at Imminent Risk of Becoming Involved with the Criminal Justice System, adopted in 2006, encourages and supports the identification, development, and implementation of an array of services and initiatives to prevent the involvement of individuals with mental illnesses or emotional disturbances, mental retardation, or substance use or co-occurring disorders in the criminal justice system. These include pre- and post-booking and pre-trial alternatives and community treatment services such as crisis intervention teams and crisis stabilization programs to divert individuals from incarceration in local or regional jails or juvenile detention facilities whenever that is legally possible and clinically appropriate.

The policy directs the Department and CSBs to respond to the needs of the courts for access to forensic evaluation and treatment services in accordance with the applicable provisions of the *Code of Virginia*. It affirms that forensic evaluation and treatment services be provided in an expedient and responsive manner and in the least restrictive manner possible to ensure that the constitutional rights of persons with a forensic status are protected and they are returned to the community as soon as is clinically appropriate and legally possible.

The policy also directs the Department to work cooperatively with the Departments of Corrections (DOC), Juvenile Justice (DJJ), and Criminal Justice Services (DCJS) and the Compensation Board and CSBs to work cooperatively with DOC facilities, DJJ correctional centers and halfway houses, juvenile detention facilities, and local and regional jails to determine how best to meet the mental health and substance abuse treatment service needs, including psychotropic medications, of inmates or juvenile detainees in those facilities.

The policy encourages and supports the identification, development, and implementation of an array of post-incarceration and re-entry services and initiatives to provide treatment and support services to individuals with mental illnesses or emotional disturbances, mental retardation, or substance use or co-occurring disorders after their release from DOC facilities, DJJ correctional centers and halfway houses, juvenile detention facilities, or local or regional jails.

Virginia needs to take advantage of community-based options to reduce demand on and prevent readmission of individuals involved with the criminal justice system to state hospitals. State hospitals provide the following services to adult and juvenile offenders:

- Evaluation of competency to stand trial,
- Evaluation of criminal responsibility,
- Emergency inpatient treatment prior to trial,
- Treatment to restore competency to stand trail,
- Emergency treatment after conviction and prior to sentencing, and
- Emergency treatment after sentencing but prior to transfer to the Department of Corrections.

For many years, state hospitals have maintained waiting lists for the admission of forensic patients for evaluation and treatment. There are approximately 50 to 80 persons waiting for admission at any given time. Approximately 35 percent of the individuals in state hospitals have been admitted from courts and jails or juvenile detention centers for treatment or evaluation. Roughly half of this group has an active status as pretrial or post sentence jail inmates, with the remainder are individuals who have been committed to the Department after being found not guilty by reason of insanity. In FY 2006, about 1,100 adult jail inmates and juvenile detention center residents were treated or evaluated in state hospitals. The Department is committed to developing an appropriate continuum of community-based solutions to resolve the problem of

prolonged waiting times for admission of jail inmates for treatment at some state hospitals. However, sufficient resources necessary for such interventions do not exist.

The Department supports a number of programs providing behavioral health services to adults in local and regional jails and children and adolescents in juvenile detention centers. The Department uses federal SAPT block grant funds to support substance abuse case management services in local jails. Three CSBs receive funds to provide intensive substance abuse treatment patterned after offender-based therapeutic communities in separate jail living areas. CSBs provide emergency services, including evaluations and preadmission screening for hospitalization, to individuals in local and regional jails and juvenile detention centers and conduct non-emergency evaluations, including evaluations of competency to stand trial, criminal responsibility, and waivers of juvenile court jurisdiction. Many CSBs provide individual and group mental health and substance abuse counseling; psychiatric services, including medication; and restoration to competency services to the offender population through local initiatives developed jointly with local and regional jails and juvenile detention centers.

CSBs also provide services through 16 adult and eight juvenile drug courts to non-violent felons who are offered this as an alternative to incarceration and treatment in jail. In addition, four localities operate family drug courts and one operates a court specifically for DUI offenders. Drug courts combine long-term (12-18 months), strict, frequent supervision by probation staff, intensive drug treatment by clinicians, and close judicial monitoring by the court.

The Department's goal of enhancing community-based restoration to competency to stand trial was reinforced by legislative action in the 2007 General Assembly session. The Department also recently funded start-up jail diversion programs in seven localities. These programs are providing enhanced access to treatment for jail inmates, with an emphasis on obtaining early release to community treatment from jail for eligible inmates.

The *Code of Virginia* requires that CSBs maintain written agreements with courts and local sheriffs relative to the delivery and coordination of services (§37.2-504). While these agreements could be strengthened and enhanced in areas such as pre-release planning, communications, and continuity of care to assure rapid connection to community services upon release, they are critically important because statutory responsibilities for the provision of treatment services to adult and youth offenders are not defined clearly.

Currently, no entity at the state or local level has clear responsibility for providing services to adult or youth offenders. By statute, sheriffs must provide all necessary health care for jail inmates. U.S. Supreme Court rulings and other legal precedents have verified that mental health care is a part of general health care for jail inmates. However, there is no requirement that jails provide their own mental health and substance abuse services, as there is for the Department of Corrections. The Virginia Administrative Code, 6VAC15-40-1010, requires jail operators to have written policies in place, including agreements with either CSBs or private contractors to provide mental health services to inmates. Specific standards for the provision of mental health and substance abuse services in Virginia jails need to be included in the Virginia Administrative Code as a first step toward insuring improved access to treatment in local correctional settings.

Standards should be established that identify the types of mental health and substance abuse services that should be available to adult and youth offenders, both in custody and in the community. These standards should address the need for the following services:

- Assessments to determine the presence of any mental illness, serious emotional disturbance, or substance use disorder and the most appropriate service dispositions for specific offenders;
- Diversion services for nonviolent adult and youth offenders;
- Treatment services provided in jails and detention centers; and

- Post-release treatment services, including specialized services such as supervised living programs.

Members of the Behavioral Healthcare Subcommittee of the Joint Commission on Health Care and the Senate Finance Public Safety Subcommittee are reviewing forensics programs that are operated by the Department. These and other stakeholders also are reviewing jail diversion strategies and other approaches to prevent the unnecessary involvement of individuals with mental illness, mental retardation, or substance use disorders with the criminal justice system and to promote optimal access to community-based treatment, whenever possible.

Veterans with Behavioral Health Issues: Governor Tim Kaine has been at the forefront of educating the Commonwealth on its responsibilities to Virginia's veterans and that these responsibilities go far beyond an enduring gratitude. In Executive Order 19 (2006) Governor Kaine states that "it is only right that our Commonwealth do all that it can to ensure that our veterans and their families receive the benefits, support, quality care, and recognition they have earned through service and sacrifice." The Governor has established an aggressive agenda for supporting Virginia's veterans, including those with behavioral health challenges. Executive Order 19 (2006) calls on each agency to identify opportunities for improving services and addressing the continuum of care needs of disabled veterans. In pursuit of the Governor's objective, the Department is forming a strong partnership with the Virginia Department of Veterans Services (DVS) across many areas of veterans care.

The Department anticipates that surging demands for behavioral health services among veterans of post-9/11 deployments will require a substantial increase in long-term behavioral health service capacity within the Commonwealth. While the actual scope of behavioral health effects from combat exposure is still under examination, initial returns indicate that it is significant. Initial studies, surveys and numbers of those seeking treatment through the Veterans Administration indicate that at least one-third of the well over a million men and women who have served in Iraq and Afghanistan are in need of some behavioral health services. Other assessment efforts and trends indicate that these levels could be dramatically understated. Analysis on the long-term behavioral health effects of operational deployments on family members remains sporadic and inconclusive; however indicators point toward a growing numbers in need of services from this cohort as well.

A recent Department of Defense (DOD) study of the mental health needs of service members returning from Iraq and Afghanistan asserts that "combat imposes a psychological burden that affects all combatants, not only those vulnerable to emotional disorders or those who sustain physical wounds." (DOD, Defense Health Board, 2007) This report further states that the behavioral health challenges on our military health system come from two "emerging" signature injuries: post-traumatic stress disorder and traumatic brain injury. Students of military and veteran history know that these "emerging" injuries are increasing in propensity from a range of complex causes. The good news is that more veterans are now voluntarily seeking assistance and treatment because of proactive programs, growing general media interest and a declining stigma associated with behavioral health.

A growing cluster of surveys, analytical studies and professional writings demonstrate that as many as half of military veterans and their families will face significant mental health challenges in the coming years. The behavioral health effects of military combat operations, since 9/11, will be equally dramatic, in fiscal terms, for the jurisdictions where these veterans choose to live following discharge from active service. Based on current rates of diagnosis reported by the VA for recently discharged veterans seeking care at VA facilities, if historic trends in the veteran portion of Virginia's population continue, Virginia could face as much as a 15 to 20 percent surge in the number of behavioral health consumers over current levels.

The Department is working with the DVS to develop a state level strategy for maintaining the behavior health of Virginia's veterans. The Department's core values and its recognition of the needs and the projected volume of veterans who are likely to need services will dictate this strategy. In conjunction with the United States Department of Veterans Affairs (VA), the Department is working to assure that CSBs are aware of the behavioral health needs of veterans -- including those still serving in the Virginia Army and Air National Guard – who reside in their service areas and to help the CSBs obtain the resources necessary to provide needed services and supports to veterans as close to their homes as possible. Pilot efforts to develop best practices in this regard will begin during FY 2008 building on existing partnerships in Northern Virginia, Hampton-Newport News, Cumberland Mountain and Richmond. These regions account for over 60 percent of the Commonwealth's veteran population or potentially about 11,000 individuals with a high probability of being candidates for behavioral health services.

Individuals Civilly Committed to the Department as Sexually Violent Predators: Sexually violent predators are convicted sex offenders who are civilly committed to the Department at the end of their confinement in the Department of Corrections because of their histories of habitual sexually violent behavior and because their ability to control their violent tendencies is compromised by the presence of a "mental abnormality" or "personality disorder". These individuals are predominantly male, on average about 40 years old. They have long histories of sexually abusing children and adults and have shown very limited ability or willingness to abstain from committing sexual offenses.

The enactment of legislation creating a civil commitment program for sexually violent predators (SVP) mandates the Department to open and operate a civil commitment program for persons found to be sexually violent predators, as defined in §37.2-900. The Virginia Center for Behavioral Rehabilitation (VCBR) is providing treatment services to individuals civilly committed as sexually violent predators. The VCBR treatment program provides individualized treatment in a secure environment. International experience with this population supports the use of a rehabilitation approach based on cognitive-behavioral principles and focused on relapse prevention. Treatment involves multiple, daily group sessions, individual behavioral therapy, vocational training, and work therapy and programs, as appropriate. Direct care staff work with clinicians to create an environment that challenges deviant and criminal thinking and behavior while reinforcing appropriate behavior.

VCBR, currently located in Petersburg, will move to a permanent 300-bed facility in Burkeville. Construction of this facility, authorized under the 2005 Virginia Acts of Assembly, Chapter 951, is underway and on schedule, with the completion of the first 100 beds scheduled for January 2008. With new standards established by the 2006 General Assembly, it is likely that the existing Petersburg facility will have to be maintained to address increased future demand.

Individuals Who Have a Co-Occurring Mental Retardation and Mental Illness: The National Association for the Dually Diagnosed (NADD) has broadly defined co-occurring mental retardation and mental illness (MR/MI) as "the co-existence of the manifestations of both mental retardation and mental illness." Persons with MR/MI can be found at all levels of mental retardation (mild, moderate, severe, profound) and can have the full range of psychopathology that exists in the general population. Estimates of the frequency of MR/MI vary widely in the published clinical literature; however, many professionals estimate that 20-35 percent of all persons with mental retardation have a psychiatric disorder. There are two major sub-groups with very different treatment needs.

- Individuals who typically have a serious mental illness and who function at the mild or moderate level of retardation (MI/MR) – This group most often resides in the community and enters the service system because of challenging, difficult-to-manage behaviors that may pose a threat of serious harm to themselves or others. Some may be at increased risk for

admission to a state hospital because they require specialized supports in a secure environment.

- Individuals who have severe or profound mental retardation and a serious mental illness (MR/MI) – This group is more likely to be receiving care in an institutional setting, whether in the community or in a state training center.

Service providers for both groups must be knowledgeable and skilled in diagnosis and treatment or habilitation of both mental illness and mental retardation.

Families and individuals receiving mental retardation services and supports often are not aware that they can have diagnoses of mental retardation and mental illness, and they sometimes fail to recognize the signs and symptoms of mental illness. This lack of awareness increases the likelihood that they will cycle between the mental health and mental retardation service systems and face multiple barriers to accessing the services and supports they need.

Providing appropriate treatment for this population has been recognized as problematic in all states. Virginia does not have a systematic approach for meeting the needs of this population. The current service delivery system is organized by program area (MH, MR, or SA), with staff training and expertise typically limited to one program area. There also is a lack of community-based expertise in diagnosing, treating, and supporting individuals who require specialized assistance. Nevertheless, there are pockets of excellence in every state, including Virginia, which could be replicated.

In the past two years, the Department has sponsored statewide training in Positive Behavioral Supports. This training has been designed to enable professionals to increase their knowledge of and to expand the number of professionals providing behavior consultation services through the MR Waiver to individuals with behavioral challenges. These multi-session training events, including subsequent mentoring by an experienced facilitator, are endorsed by DMAS. These interventions are an approved MR Waiver service component.

Individuals Who Have a Co-Occurring Substance Use Disorder and Mental Illness: Co-occurring substance use disorders and mental illnesses (SUD/MI) are characterized by the simultaneous presence of two independent medical disorders – psychiatric disorders and alcohol and other drug use disorders. Co-occurring disorders can occur at any age. Of those Virginians with an addictive disorder, 42.7 percent or 238,098 individuals also had a least one mental disorder during the 12-month period, according to the *Report to Congress on the Prevention and Treatment of Co-occurring Substance Abuse Disorders and Mental Disorders*.

Individuals with SUD/MI challenge the treatment system. Three major systemic barriers restrict services to persons with co-occurring disorders – restricted services funding, the lack of specifically designed programming, and lack of trained professionals. In 2004, the Department was awarded a federal State Incentive Grant for the Treatment of Persons with Co-occurring Substance Related and Mental Disorders (COSIG) grant. This five-year grant, renamed the Virginia Service Integration Program (VASIP), involves 11 CSBs and will validate instruments for the screening of co-occurring disorders at the pilot sites, build capacity of the existing infrastructure by documenting the knowledge and skills of the current workforce; and provide training delivered by nationally recognized experts on evidence-based and culturally competent treatment practices for individuals with co-occurring disorders.

Integrated treatment, as opposed to sequential or parallel forms of treatment, offers the most positive outcomes for individuals experiencing co-occurring disorders. (RachBeisel, Scott, and Dixon 1999; Drake et al., 2001, Schneider 2000, Drake and Wallach 2000) As part of the VASIP initiative, the Department is promoting the adoption of the *Comprehensive, Continuous, Integrated System of Care (CCISC)* model at all levels of the services system. CCISC is designed to be an accepting umbrella for all best practices in the treatment of individuals with co-occurring disorders. It incorporates the principles of integrated system planning; a

welcoming environment, uniform program capability in dual diagnosis; universal practice guidelines; dual competence; concurrent treatment for simultaneous primary disorders; ease of access; treatment matching to subtypes of dually diagnosed individuals; utilization of parallel phases for treatment planning; readiness stages are not a barrier; treatment over time; and maintaining continuity of relationships with clinicians. (Minkoff, 1989, 1991, 2000, 2001)

In 2005, the Department was awarded a federal State Adolescent Treatment Coordination (SAC) grant to develop necessary infrastructure to support the development and provision of substance abuse treatment services for youth who have a substance use or co-occurring disorder. The three-year SAC grant focuses on funding and promotion of evidence-based practices, collaboration across state systems, workforce development, and development of family support and advocacy efforts. Grant activities have included the establishment of an interagency workgroup to identify and address infrastructure needs across systems. An adolescent services provider network also has been created. The grant also has supported provision of technical assistance and training in evidence-based programs to interested CSBs and training across systems in adolescent best practices.

Through the VASIP and SAC initiatives, the Department is working to establish a more comprehensive approach for technology transfer for both central office and CSB staff that will promote consensus and evidence-based approaches in treatment delivered to individuals with both mental illnesses and substance use disorders. Despite these considerable efforts, Virginia does not yet have a distinctive, planned, comprehensive and coordinated approach to delivering services to individuals with co-occurring disorders.

Individuals Who Are Deaf, Hard of Hearing, Late Deafened, or Deafblind: The Department's Advisory Council for Services for People Who Are Deaf, Hard-of-Hearing, Late Deafened, or DeafBlind (Advisory Council), composed of service providers and state agency representatives, is charged with assessing critical needs for this population, providing service oversight, and recommending future direction for service improvements and development in all three program areas. The Advisory Council has noted that hearing loss affects 8.6 percent of the general population. Between five and 10 percent of these individuals also experience a loss of vision. Research generally suggests that the prevalence rates for serious mental illness within the deaf, hard of hearing, late deafened, and deafblind populations are consistent with those found in the general population. Some studies suggest a higher prevalence rate for adjustment and personality disorder, emotional or behavior dysfunction, and substance use disorders. Contributing factors to this may include isolation due to communication barriers, lack of family support, underemployment, late onset of hearing loss, and lack of social identification.

Communication barriers associated with hearing loss also prevent access to CSB programs, resulting in the need for specialized and accommodated services for this population. The Department is committed to improving the capacity of the service system to address the communication and cultural access needs of this special population to ensure availability and access to needed specialized resources, professionals, support services, and technical assistance on a regional basis. Four years ago, the Advisory Council identified the following issues for action during the next three biennia:

- State facilities and CSBs could benefit from additional technical assistance and resources to address the communication and cultural needs of this population;
- Regional programs need additional resources to meet the service needs of this population; and
- Inter-regional collaboration is needed to ensure the continuity of care and the effective provision of mental health, mental retardation, and substance abuse services.

Implementation of Evidence-Based and Best Practices

Evidence-based practices (EBPs) are those interventions that integrate the best research evidence with the best clinical expertise and values focused on individuals receiving services (Institute of Medicine Report Crossing the Quality Chasm, 2001). Evidence-based practices emphasizing individual participation, choice, recovery, and self-determined outcomes have the potential to significantly improve the quality of life for individuals receiving services. The 1999 *Surgeon General's Report on Mental Health* underscored that, for the most part, the effective interventions that exist for many mental disorders are simply not available to the majority individuals who could benefit from them. Evidence-based practices for the treatment of serious mental illnesses in adults and serious emotional disturbance in youth include:

For adults with serious mental illness or co-occurring substance use and mental health disorders:

- Co-Occurring Disorders: Integrated Dual Disorders Treatment
- Illness Management and Recovery
- Medication Management Approaches in Psychiatry
- Family Psychoeducation
- Supported Employment
- Assertive Community Treatment (ACT)
- Motivational Enhancement Therapy (MET)
- Cognitive Behavioral Therapy (CBT).

For children and adolescents with emotional disturbance or substance use disorders:

- Multi-systemic Therapy (MST)
- Functional Family Therapy (FFT)
- Motivational Enhancement Therapy (MET)
- Cognitive Behavioral Therapy (CBT)
- Cannabis Youth Treatment Services (MET/CBT)
- Seeking Safety
- Integrated Community Treatment
- Therapeutic Foster Care
- Many prevention interventions.

Virginia has made significant progress in implementing selected evidence-based practices. Most individuals have access to "new generation" medications, whether in CSB or state facility programs. There are 19 Assertive Community Treatment Teams serving 18 CSB service areas. Sixteen of these teams are licensed Programs of Assertive Community Treatment (PACT) teams and three are licensed Intensive Community Treatment (ICT) teams. Together, these programs served 1,373 individuals in FY 2006. Outcome data from the PACT initiatives have shown dramatic reductions in state hospital usage, increased stability in living situations for individuals, and reduced involvement with criminal justice agencies. The Department provided federal funds from the COSIG grant to Central Virginia Community Services and the Valley Community Services Board to implement the first Integrated Dual Disorders Treatment (IDDT) programs in the state. These CSBs are implementing IDDT within their existing PACT programs. The Department also supports family psycho-education through its contracts with family support groups and the Southwest Virginia Behavioral Health Board. Most individuals receiving services in the public mental health system, however, do not have consistent access to evidence-based services.

In FY 2005, the Department was awarded a three-year $300,000, Real Choice Systems Change Grant from CMS to support infrastructure development of the evidence-based practices for adults with serious mental illnesses. This grant is intended to align Virginia's existing community mental health Medicaid Rehabilitative Services with the evidence-based practices of assertive community treatment (ACT), illness management and recovery (IM&R), and supported employment (SE) and to maximize opportunities for peer specialists and peer-operated programs. Grant activities have focused on consensus and partnership building with multiple stakeholders to develop Virginia-specific models of IM&R and SE; conduct regulatory analysis and provide a clear articulation of Department, DMAS, and DRS funding streams that support PACT, IM&R, and SE services; provide training, consultation, and technical assistance to providers; evaluate implementation and measure fidelity to the models and individual outcomes; and develop plans to expand, sustain, and maintain a high level of quality services.

In the area of mental retardation, challenging behaviors can adversely affect an individual's abilities and opportunities to participate fully in any aspect of community life. Positive Behavior Support (PBS) offers a comprehensive, science-based approach to behavior change that teaches people with challenging behaviors and the people who support them new skills for successful living in the community. PBS integrates behavioral technology with person-centered values and has been successful with children and adults who have mental retardation or other developmental disabilities. An endorsement in PBS has been an accepted credential for the provision of MR Waiver behavioral consultation services since July 2006. Since that time, the number of PBS-endorsed behavior consultants has steadily risen across the state.

Recognition that adolescent issues and needs and differences in their patterns of substance use has led to greater efforts to develop developmentally appropriate and gender-specific services. In 2007, the Department received a three-year $1.2 million State Adolescent Training Coordination grant to develop state level infrastructure to support treatment services for adolescents with a substance use or co-occurring substance use and mental health disorder. Training offered at eight sites across Virginia through this grant promoted the implementation of evidence-based practices. Following this training, CSBs were invited to apply for technical assistance and skills-based training in an evidence-based program of choice. The intent is to enable 20 CSBs to assess their system needs and available resources and to guide them through the process of selecting and developing the staff skills necessary to implement an evidence-based practice.

Several initiatives are helping to increase the use of substance abuse evidence-based practices in CSBs and their contract agencies. Guidance bulletins have been distributed to the CSBs that identify "best practices" in specific areas of clinical practice. Regularly scheduled technical support visits to CSBs provide assistance in clinical issues, including identifying clinical practice models and assisting with evaluation design. Additional training and technical is available through departmental and grant-funded initiatives to support the adoption and implementation of evidence-based programs for youth.

Experts in the field of prevention have developed rigorous approaches to evaluate and identify prevention programs that are effective. These programs are recognized by state and federal mental health, substance abuse, education, and juvenile justice systems as evidence- or science-based programs. The Department currently funds 12 science-based prevention programs for families, including services for new parents, Head Start children and their parents, and families with children and adolescents. Program directors are working closely with program developers and university faculty to evaluate the programs. Thus far, program evaluation data indicate that children gained in their awareness of drug harm and increased their levels of cooperation and social skills. Evaluation results for parents show fewer inappropriate parental expectations and increased overall parenting and monitoring skills. Evaluation of the families showed an increase in communication skills and family interaction.

The Department must increase its focus on adopting evidence-based practices to effectively achieve its mission. Advances in communication technology greatly enhance the dissemination and transfer of information to practitioners and can make the most current research and practice information readily accessible to most practitioners, allowing them to integrate this information into their daily practice. To strengthen Virginia's services system through this technology, several ingredients must be in place, including

- Commitment of leadership at each level (state, local, program),
- Education and skill building for practitioners,
- Supportive administrative practices,
- Incentives and rewards,
- Feedback mechanisms (e.g., measurement of outcomes), and
- Stable long-term financial support for EBPs.

Additional resources will be needed to raise awareness of evidence-based practices, enhance provider competency, and develop and sustain programs and services.

State Hospital and Training Center Services

State hospitals and training centers continue to be critical components in the continuum of care for individuals with mental illness, intellectual disabilities, or substance use disorders.

***State Hospitals**:* State hospitals provide a variety of clinical services that are not available in all communities and are structured to best meet each individual's needs and include: psychiatric assessment and stabilization; medication management; nutritional management; psycho-social rehabilitation programming; psychiatric and rehabilitative therapies; and, in collaboration with the CSBs, discharge planning. Services are further specialized by the age groups served at a facility and incorporate cultural competency. These facilities provide services and supports to persons with serious mental illnesses and serious emotional disturbances who are in crisis, who present with acute or complex conditions, or both, and who require the highly intensive and structured environments of care only available in an inpatient setting. Services provided by state hospitals focus on psychiatric stabilization and development of skills needed for successful community living. These services enable individuals to develop skills and supports needed for success and satisfaction in specific environments and enhance other fundamental life skills, such as developing trusting relationships, increasing hope, motivation, and confidence, and making informed choices.

State Training Centers: State training centers provide services and supports to persons with intellectual disabilities who require the highly intensive and structured environments of care. Training center services include medical and psychiatric assessment, preventive and general healthcare, medical stabilization, habilitation, and development of skills needed for successful community living. Although long-term care has been their main function, training centers also provide short-term respite care and emergency care. All training centers meet federal requirements for designation as Intermediate Care Facilities and one, CVTC, also operates skilled nursing and acute care beds. Training centers also address the needs of individuals with mental retardation and co-occurring mental illness or challenging behaviors and persons with co-occurring severe developmental disabilities and medical complexity. The training centers are also beginning a cultural transition to person-centered planning processes and are expanding their mission to make short-term and transitional facility-based services more readily available. This transition is the subject of an assessment by the Office of the Inspector General (OIG).

The training centers serve two very distinct populations: individuals with mild to moderate levels of mental retardation with co-occurring mental illness and challenging behaviors and individuals with severe and profound levels of mental retardation with very compromised and complex physical and medical conditions. All five training centers are experiencing greater demands to

serve persons who have mild or moderate mental retardation and challenging behaviors that require significant behavioral interventions. The Department and training centers have identified the need for specialized residential living units (e.g., smaller units with more robust staffing levels) to specifically address the needs of individuals with dual diagnoses or special behavioral considerations. Such programs, which seek to return individuals to their community placements within a year, require enhanced resources to provide more intensive treatment and more formalized training. In addition, community consultations are being provided to divert potential admissions and stabilize residents in their community placements. The training centers need resources to expand these behavioral management teams, which require smaller caseloads and additional psychologists, and ultimately more resources.

A large proportion of individuals served by training centers is non-ambulatory (requiring specialized wheelchairs) or need significant staff assistance to walk. Many have multiple, complex medical conditions such as seizures, scoliosis, gastrointestinal problems, hearing or visual deficits, or both, or speech impairments. These medical needs are projected to increase in the years to come because the training center population is aging. All of these conditions make appropriate staffing critical to the well being of these individuals.

***Regional Community Support Centers**:* Selected state facilities serve as the hub of community support programs known as Regional Community Support Centers (RCSCs). RCSCs are presently operated in all five training centers and the Northern Virginia Mental Health Institute (NVHMI). Services offered by the training center RCSCs are not available in the community and vary among the regions, depending on regional needs and resources. A recent survey to determine the scope of community needs that could be addressed by RCSCs has documented needs that exceed existing resources. Current services include camps for children with autism, dental services, pediatric neurology clinics, therapeutic recreation and swimming, and specialized behavioral interventions.

The newly established NVMHI RCSC will serve as a hub for regional activities designed to empower consumers to prevent and manage behavioral emergencies in ways that are fully aligned with a recovery-based system of care. This RCSC is funded through Transition Initiative recovery funds allocated to each region. The RCSC recently sponsored a conference with over 200 attendees and has received requests from regional crisis care settings to assist them.

Creating a Recovery-Oriented and Person-Centered Planning Environment: All state facilities self-monitor and work with central office staff to insure that continuous facility improvement plans are successfully implemented and maintained. Central office staff also works with state facilities to address and monitor facility-specific improvement plans that respond to the findings of external consultants, Departmental internal audits, the OIG, and the Virginia Office of Protection and Advocacy (VOPA). The OIG inspects, monitors, and reviews the quality of services provided in state facilities and by licensed providers, including CSBs, private providers, and DOC mental health units. The OIG conducts announced and unannounced inspections and investigations that result in findings and recommendations to the state facility or licensed provider. The OIG reports all findings, recommendations, and progress made toward implementing recommendations to the Governor and the General Assembly.

In 2004, the OIG initiated systemic reviews of the state hospitals and training centers. Key domains used to inspect and evaluate state facility performance included the facility mission and values, individual access and admission, service provision and individual activities, facility operations related to individual and staff safety, facility operations related to living environments, staffing patterns, system performance, and community relationships. The resulting OIG reports included system-wide and facility-specific recommendations for change

From December 2006 to February 2007, the OIG conducted a review of the eight state hospitals that serve adults to assess the recovery experience of persons who are served at these facilities, specifically the extent to which their experience reflected the principles of recovery,

self-determination, and participation. This project included announced visits to each hospital, unannounced observations of treatment teams, and a follow-up survey. Findings focused on treatment planning partnership, choice, involvement in valued roles, relationships that support recovery, and provision of a supportive environment for recovery. The OIG recommended that each state hospital develop and implement, by August 30, 2007 a Comprehensive Facility Plan on Recovery that addresses the role of senior leadership, workforce development, treatment planning, clinical record design, resident activities and opportunities, relationship to the community, and other areas to enhance the recovery experience. The OIG also recommended that each state hospital prepare and submit semi-annual implementation progress reports to the OIG during 2008 and 2009. The OIG is conducting a review of the training centers to assess the extent to which residents experience person-centered planning and self-determination.

As critical partners in the system transformation initiative, the state hospitals are working to change the culture of mental health inpatient services to one that support recovery, self-determination, empowerment, and person-centered planning. The Department intends to offer a conference that will focus on enhancing workforce knowledge and skills to help realize the Department's vision of an individual and family-centered system of care that supports recovery, self-determinations, and empowerment. The conference will draw upon the experiences and expertise of individuals, family members, local providers, and national experts.

State Facility Medication Management and Medicare Part D Implementation*:* All state facilities are serving proportionately greater numbers of individuals with significant and complex psychiatric and medical conditions that require specialized pharmacologic interventions. In an effort to contain spiraling drug costs, the Department is developing a Medication Management System as part of an agency electronic health record. This system should improve linkages between critical databases, allowing facilities to improve individual care and clinical outcomes and to promote safe, effective, and efficient pharmacy services.

A new Medicare drug benefit, Medicare Part D, went into effect on January 1, 2006. Under this benefit, drug coverage is offered through private sector prescription drug plans and Medicare advantage plans. Billing for Medicare Part D originates within the state facility pharmacy departments, which has necessitated pharmacy system software upgrades and intense staff training and education. Although state facility pharmacies are struggling to retain qualified pharmacy positions and maintain competitive salaries, state facility pharmacies are transitioning to 30-day pharmacy reviews required by the Code of Virginia. These reviews will require additional pharmacists and pharmacy technicians.

State Facility Staffing: The Department must ensure that each state facility has sufficient numbers of trained personnel across the entire spectrum of clinical and direct care positions to provide quality care and person-centered services. Sufficient staffing is absolutely necessary to provide appropriate assessment, treatment, rehabilitation, training, and habilitation in accordance with clinical standards in a safe treatment environment. In keeping with transformation objectives and current practice guidelines, the state facilities are transitioning to more person-centered processes, services, and planning activities for their populations. As part of this transition, several state facilities have increased their staffing ratios somewhat by reducing bed demand through community initiatives such as DAP, PACT, regional management of local bed purchases and utilization of state hospital beds, and MR waiver services.

However, state facilities continue to experience staffing level issues, perhaps most notably Southern Virginia Mental Health Institute (SVMHI). Additionally, Central Virginia Training Center (CVTC), Southeastern Virginia Training Center (SEVTC), Southside Virginia Training Center (SVTC), and Southwestern Virginia Training Center (SWVTC) continue to experience difficulty recruiting and retaining nurses and direct care staff, psychiatrists, psychologists, primary care physicians, dieticians, occupational and physical therapists, rehabilitation engineers (for specialized wheelchairs), speech pathologists, and audiologists. Factors influencing these staffing issues include the lack of competitive salaries; the lack of qualified and trained applicant

pools; increasing fuel costs, especially for employees living in rural areas; and the inability to offer incentives to match the competitive market.

Prevention Service Priorities

Substance Abuse Prevention: Prevention is aimed at substantially reducing the incidence of alcohol, tobacco, and other drug use and abuse, with a focus on the enhancement of protective factors and the reduction of risk factors. Prevention services include activities that involve people, families, communities, and systems working together to promote their strengths and potentials. Effective prevention services reduce the number of new cases of substance use disorders by reducing risk factors and increasing protective factors. Risk factors may be biological, psychological, social, or environmental and can be present in individuals, families, schools, and the community. When a child experiences a higher number of risk factors, such as poor school achievement, parents with poor family management skills, and neighborhoods where drug use is tolerated, the child is more likely to experiment and use alcohol, tobacco, or other drugs. Protective factors, such as social and resistance skills, good family and school bonds, and the capacity to succeed in school and in social activities, can reduce the impact of risk factors. Human service providers, schools, law enforcement organizations, faith and business communities, and parents and youth work together in prevention planning coalitions to plan and implement prevention programs and strategies that strengthen protective factors while reducing risk factors in all domains of individuals, homes, schools, and the community.

The Department oversees and manages substance abuse prevention services delivered through the CSBs. Currently, most community-based prevention services are funded with the SAPT Performance Partnership Grant and meet federal regulations that direct their use. Other funds for prevention services are available through competitive grant process from several state and federal agencies. Through collaborative efforts in the Governor's Office on Substance Abuse Prevention and federal agencies, most requirements for prevention programs and processes are the same or similar.

The Department adopted a community-based prevention planning process in 1995. Through this process, CSBs work with human service, education, and local government representatives to conduct needs and resource assessments; identify service gaps and unserved populations; and plan, implement, and evaluate prevention programs and environmental strategies that address identified risk factors. In a survey conducted for the 2008-2014 Comprehensive State Plan, CSBs reported that prevention planning groups identified availability of drugs, family history of problem behavior, early initiation of problem behavior, and family management problems as the most significant risk factors. Populations identified as in need of services were elementary and middle school students. The Prevention and Promotion Advisory Council to the State Board has also identified the need to focus on prevention services for the family.

A FY 2005 statewide youth survey found that 35 percent of the surveyed youth said alcohol, cigarettes, and drugs were easy to obtain, a decrease from the 44 percent in the 2000 survey. The mean age of first use of tobacco products by Virginia youth increased to 12.29 from 12.25 years in 2000. The mean age of first use of alcohol increased from 12.29 in 2000 to 13.23 years in 2005, with 14.43 percent of the youth reporting that they were drinking regularly in 2005, a decrease from 14.51 percent in 2000. The increase in the age of first use and the small decrease in the percentage of youth drinking regularly may reflect a positive trend that was supported by the increased use by CSBs of evidence-based prevention programs. Continuation of these services is required to continue this downward trend of youth substance use in Virginia. On a less positive note, inhalant abuse, which has only recently been addressed, has increased in past 30-day use from 4 percent in 2000 to 6 percent in 2005, with 8 percent of Virginia's 8th graders now using inhalants in the last 30 days. This is twice the national average for the same time period.

Suicide Prevention: Pursuant to the report titled *Suicide Prevention Across the Lifespan Plan for the Commonwealth of Virginia* (SD 17, 2004) the Department was designated by the General Assembly as the Commonwealth's lead agency for suicide prevention across the life span in 2005. Other agencies involved in this effort include the Department of Health, the Department for the Aging, the Department of Juvenile Justice and the Department of Corrections. Together, the agencies work to promote awareness throughout Virginia aimed at reducing suicide across the life span. Broad goals of the plan include: prevention of death from suicide, reduction of the occurrence of other self-harmful acts, increased risk recognition and access to care, promotion of the awareness of suicide, reduction of the stigma associated with suicide; and leadership and infrastructure development. Implementation of *Suicide Prevention Across the Lifespan Plan for the Commonwealth of Virginia* has been hampered by the lack of dedicated resources at the Department.

Prevention of Youth Access to Tobacco Products: The Synar Amendment to the federal Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act requires that states conduct annual inspections of randomly selected tobacco retail outlets to determine how likely it is that underage youth are able to purchase tobacco products. The states must conduct compliance inspections of tobacco vendors as a condition for receipt of Substance Abuse Prevention and Treatment Block Grant funds, which support community substance abuse treatment and prevention services and total $42.94 million. The rate of noncompliance must not exceed a previously agreed upon target rate, or 20 percent noncompliance by FFY 2003. The current rate of 10 percent is well below the required target of 20 percent.

Disaster and Terrorism Preparedness and Recovery

***Services System Preparedness*:** Virginia is the fifth most likely place for a disaster to occur in the United States. The Commonwealth has experienced as many disasters in the last ten years as Texas and California, the two most frequently declared states for major disasters. The continuing threat of terrorism, such as that which occurred September 11, 2001, the serial sniper attacks, natural disasters such as Hurricane Isabel, and, more recently, the Virginia Tech shootings, make it clear that the Virginia behavioral health system must be ready to respond. Virginia's first-hand experiences with disaster response have unequivocally confirmed that a rapid, efficient behavioral health response does assist individuals and communities in the recovery process. Following the attack on the Pentagon, Virginia initiated a crisis-counseling program, the Community Resilience Project, which was administered by the Department and delivered by the Northern Virginia CSBs. The project remained in full operation for 30 months and resulted in 683,000 crisis contacts and the distribution of more than 1.4 million pieces of educational literature to assist in coping and recovery. Similar crisis programs following Hurricane Isabel and other major events have supported countless Virginians. In the aftermath of these highly effective and successful behavioral health response initiatives, the services system is increasingly recognizing the importance of behavioral health as a critical and vital component in all aspects of emergency mitigation, preparedness, response, and recovery in state and local plans.

The Department is responsible for disaster and terrorism planning, preparedness, and response activities for the behavioral health services system. During a disaster situation, the Department performs immediate response and coordination activities with other state agencies, state facilities, and CSBs. This includes coordinating and preparing federal grants to secure federal emergency response funding and assuring the provision of accurate, timely, and instructive information to the public and services system constituents.

The Department convened a Facility Preparedness Workgroup, consisting of state facility staff, to plan, prepare, and coordinate the Department's facility assets and currently chairs the Terrorism and Disaster Behavioral Health Advisory Council, (TADBHAC), a group of experts convened by the Governor to guide and inform the Commonwealth on behavioral health and

disaster preparedness and response best practices. Additionally, the Department has worked to strengthen vital public-private partnerships needed to assure an appropriate emergency response. It has developed and implemented training curricula for state facility, CSB, and public sector staff on emergency mental health response interventions and has establishing protocols for the development of mutual aid agreements among and between state facilities, community hospitals, and other health care organizations in Virginia. In June 2007, the Department entered into an agreement with SAMHSA under the Intergovernmental Personnel Act of 1970 to assign a SAMHSA employee with extensive experience in disaster behavioral health response at the federal level and state levels to the Department on a full time basis for two years.

State Facility Preparedness: JCAHO emergency management standards require hospitals and long term care facilities to engage in cooperative planning with other health care organizations (e.g. other hospitals providing services to a contiguous geographic area) to facilitate the timely sharing of information, resources, and assets in an emergency response. State facilities have engaged in local and statewide planning processes that have resulted in identification and pooling of assets and regional evacuation planning. While state facilities are poised to assist in any community emergency response, Department policy requires that facility resources and assets first be made available to respond to the needs of individuals receiving state facility services and staff. Several state facilities have partnered with regional emergency planning efforts to increase regional hospital surge and response capability. An analysis of state facility assets conducted by Facility Preparedness Work Group determined that significant additional funding is needed to increase emergency generator capacity at those facilities.

Community Services Board Preparedness: CSBs have developed All-Hazards Disaster Response Plans that include attention to each stage of an emergency event. These plans will be used to assure CSBs are prepared to respond to all types of disasters that may occur in their service areas. Additionally, CSBs have undertaken efforts to develop collaborative relationships with their local public health departments and emergency management agencies. Through the availability of Virginia Department of Health funds, CSBs have participated in regional training forums on disaster response and behavioral health interventions. Emphasis for the upcoming year will include additional disaster response training and development of memorandums of understanding with local response partners. In 2007, regional training was conducted to enable CSBs to provide training to their local response partners. This training was provided in conjunction with the Virginia Department of Health; training curricula was developed and presented by members of TADBHAC.

Goals, Objectives, and Action Steps

Goal 7: Promote the concepts of treatment in the most integrated settings and individual and family choice that are central to the U.S. Supreme Court Olmstead Decision.

Objectives:

1. Work collaboratively on an ongoing basis with the Secretary of Health and Human Resources (HHR), the Community Integration Oversight Advisory Committee, the Community Integration Implementation Team, and all State agencies involved in implementing recommendations in the Olmstead Task Force Report.

Action Steps:

a. Monitor the appropriate movement of discharge ready individuals from state facility to community-based services.

b. Monitor Department and system's efforts toward maintaining youth in the community following their transition to adult services.

c. Working with all appropriate stakeholders and other state agencies, as appropriate, prepare legislative and budget proposals to implement Olmstead Task Force recommendations for consideration by HHR, DPB, and the Governor.

d. Participate in the Money Follows the Person Demonstration initiative.

e. Provide reports on the status of discharge ready individuals to the State Human Rights Committee, local human rights committees, and human rights advocates.

2. Participate with the Community Integration Oversight Advisory Committee and the Community Integration Implementation Team in planning and implementing Virginia's response to the Olmstead decision.

Action Steps:

a. Prepare information, analyses, and reports as requested.

b. Contribute to the annual reports submitted to the committee.

Goal 8: Expand and sustain services capacity necessary to provide services that promote recovery, resilience, self-determination, and person-centered planning when and where they are needed, in appropriate amounts, and for appropriate durations.

Objectives:

1. Establish community services and supports that that minimize crises, reduce reliance on the most intensive levels of care, and promote independent living and individual and family choice.

Action Steps:

a. Develop strategies to address critical community service deficits, including the needs of individuals on CSB mental health, mental retardation, and substance abuse services waiting lists and the inflationary pressures on services sustainability.

b. Standardize emergency and crisis stabilization services to best practices and improve the capacity of these services to address the complex needs of consumers in crisis who have co-occurring disorders.

c. Standardize case management and rehabilitation services to recovery-oriented and person-centered principles and practices.

d. Support CSB efforts to acquire staff expertise and infrastructure needed to conduct thorough utilization management and review of the psychiatric inpatient services provided in state hospitals or purchased in local hospitals.

e. Expand the number of purchased local psychiatric inpatient, psychiatric and medication, and intensive residential services delivered by all CSBs.

f. Establish intensive community services capacity that provides alternatives to and timely discharge from psychiatric hospitalization and promotes community integration.

g. Expand the number of discharge assistance project placements that enable individuals in state hospitals to transition to successful community placements.

h. Expand community services and increase the availability of evidence-based programs and other services designed to treat co-occurring substance abuse and mental health disorders according to principles of best practices.

i. Work with DMAS to secure additional MR Waiver slots to address current waiting lists.

j. Establish intensive community capacity and behavioral consultation services that provide alternatives to training centers and promote community integration.

k. Develop innovative ways to serve children and adults who have mental retardation but who are not eligible for the MR waiver.

l. Expand Part C early intervention services for infants and toddlers (ages 0-3) and their

families to prevent or alleviate later developmental or learning problems.

m. Implement additional systems of care projects to serve children and adolescents.

n. Expand the number of guardianships CSBs support for individuals who require substitute decision makers to facilitate their transition from state hospitals to community services or to enable them to receive services for which informed consent is required.

2. Strengthen the services delivery system for people with intellectual disabilities.

Action Steps:

a. Explore with DMAS the feasibility of changing home and community-based waiver policy, regulations, and reimbursement systems to allow the program to be more flexible and responsive to the needs of individuals with intellectual disabilities.

b. Explore with DMAS the possibility of adding new services to the MR waiver, including nutrition consultation, pharmacy consultation, ethicist consultation, chore services, housing access coordination, dental, transportation, and caregiver living expenses.

c. Explore with DMAS the possibility of providing a reserve of waiver slots for crises that emerge during the year.

d. Explore with DMAS the possibility of amending Virginia's Medicaid Buy-in program to enable individuals who are otherwise ineligible for Medicaid because of earned or unearned income to pay a premium to obtain Medicaid coverage.

e. Expand family supports and other initiatives that allow individuals to have control over how their service dollars are spent.

f. Work with DMAS and TACID to replace the current diagnostic tool for waiver services.

g. Work with DRS and the Department of Education to facilitate access to post-secondary transition services.

h. Continue to provide training to case managers and direct care staff on person-centered practices and state waiver and licensing requirements.

i. Enhance central office administrative infrastructure to monitor existing services and maintain compliance with CMS expectations.

3. Support efforts in the New River Valley and across Virginia to respond to and recover from the tragedy at Virginia Tech.

Action Steps:

a. Provide community outreach, emergency services, risk assessments, and short-term crisis counseling to individuals affected by the tragedy at Virginia Tech with federal State Emergency Response Grant (SERG) funds.

b. Increase the capacity of Virginia's behavioral health services system to provide secure crisis stabilization programs, outpatient treatment services, and case management services as recommended in the OIG investigation of the Virginia Tech tragedy.

c. Provide outreach to key colleges and universities throughout the State, mental health consumer organizations, and the Asian/Korean cultural populations.

d. Develop and implement a public education campaign focused on crisis mental health prevention, expected reactions to traumatic events, and coping skills.

e. Develop and implement a stress management program for individuals involved in responding to the Virginia Tech tragedy.

4. Provide appropriate, effective, and efficient state facility pharmacy and Community Resource Pharmacy services.

Action Steps:

a. Assess physician prescribing practices, identify prescribing issues, and provide follow-up actions.

b. Implement physician prescribing practice notifications by identifying patterns of repetitive medication returns to the Community Resource Pharmacy and notifying the appropriate physician or designee

c. Maximize utilization of the Community Resource Pharmacy's "Medsavers" program.

d. Monitor state facility and Community Resource Pharmacy medication inventories to ensure availability of normal stock levels and eliminate excessive inventories.

e. Evaluate the system's capacity to bill a variety of third party insurance plans and for individuals who participate in state facility pharmacy and Community Resource Pharmacy programs.

f. Evaluate the impact of Medicare Part D on the Department and services system.

g. Evaluate and ensure that current state facility pharmacies' procedures and capabilities comply with state requirements and federal programs.

h. Continue to support and communicate with CSBs regarding consumer eligibility for Medicare and Medicaid and their prescription coverage from the Community Resource Pharmacy and state facility pharmacies.

i. Implement a Pharmacy Assistance Program to support Medicare D eligible clients when they reach the "Doughnut Hole."

5. Establish funding mechanisms that blend funding streams and allow flexibility in creating individualized recovery-oriented and person-centered plans for youth and adults.

Action Steps:

a. Assess the extent to which federal and state requirements allow or prohibit blending or braiding of funding streams and whether waivers might be sought.

b. Assess the feasibility of implementing self-directed care models in Virginia.

c. Develop policies and procedures for integrating existing Department funding streams in ways that support individualized and flexible delivery of services and supports.

Goal 9: Promote the establishment of an integrated system of service delivery that implements the core values of resilience, self-determination, and person-centered planning and is responsive to the mental health, mental retardation, and substance abuse needs of children and adolescents and their families.

Objectives:

1. Take steps to implement the continuum of mental health, mental retardation, and substance abuse services for children and adolescents.

Action Steps:

a. Implement evidence-based initiatives that expand systems of care in selected localities.

b. Develop new and expand existing child and adolescent services and linkages with local schools to fill gaps and build community capacity.

c. Develop and implement community services for youth who are transitioning from children's services to young adult (ages 17-21) services.

d. Increase the number of fellowships and expand training and education opportunities to increase the numbers of child psychiatrists, child psychologists, and other difficult-to-recruit clinicians practicing in Virginia.

e. Provide ongoing behavioral health care training to child and adolescent behavioral health services providers and health care professionals such as pediatricians, family practitioners and primary care physicians.

f. Support training efforts across systems to increase providers' knowledge regarding best practices and support necessary skill development.

2. Continue to work to improve access by children, adolescents, and their families to mental health, mental retardation, and substance abuse services.

Action Steps:

a. Continue to support the efforts of the CFBHPPC to identify service needs and update the integrated policy and plan required by the Appropriation Act.

b. Provide leadership, policy development coordination, and planning for children with behavioral health needs with state and local agencies to maximize resources for children's behavioral health services.

c. Conduct a detailed analysis of the needs of medically fragile children with mental retardation.

d. Work with VFOF, a statewide family support coalition, to link existing family support organizations and groups into a cohesive voice for children.

e. Support the activities of the state advisory committee for child and family services to the Department.

f. Support efforts to screen and refer children who are between 0-3 years old and who may exhibit or are "at-risk" for developmental delay or mental health issues.

g. Establish an interactive web site that can serve as a resource for parents and youth.

Goal 10: Promote the development of a comprehensive array of specialized prevention and treatment services and supports for older adults with mental health and substance use disorders.

Objectives:

1. Develop a comprehensive, community-based continuum of mental health, mental retardation, and substance abuse services for older adults in Virginia.

Action Steps:

a. Work with CSBs, community providers of aging services, and community organizations to raise their awareness of the mental health, mental retardation, and substance abuse service needs of older adults.

b. Provide technical assistance and training on service models that respond to the mental health, mental retardation, and substance abuse service needs of older adults.

c. Work with the CSBs to establish a dedicated capacity in each CSB for responding to the services and support needs of older adults.

d. Coordinate with DMAS to explore the feasibility of expanding the PACE and other "money follows the person" initiatives.

e. Continue to allocate OBRA funding on an annual basis to individuals in nursing homes with intellectual disabilities with specialized services needs.

f. Work with the CSBs to implement two regional demonstration programs for older adults.

g. Develop a directory of older adult services available in Virginia that describes available services and supports, entitlements, and how to access services.

h. Explore potential financial resources for the development of individual-centered, family-focused, community-based services for elderly individuals that reflect best practices.

i. Explore service models that would assist nursing home and assisted living facility operators to effectively manage defined behaviors such as wandering and aggression that routinely result in expulsion from nursing homes and assisted living facilities.

j. Work with the DMAS to establish a support model for older adults who are receiving MR waiver services.

k. Participate with the Department for the Aging in the implementation of nine "no wrong door" Decentralized Resource Centers funded through an Aging and Disability Resource Center grant.

Goal 11: Enhance Virginia's capacity to intervene and divert individuals with mental illness or substance use disorders from the criminal justice system and provide behavioral health evaluation and treatment services to individuals involved with the criminal justice system.

Objectives:

1. Develop jail and community-based behavioral health services for individuals involved with the criminal justice system pursuant to State Board Policy 1041.

Action Steps:

a. Expand the number of jail-based behavioral health teams, improve access to medications, and develop community diversion and post-release services.

b. Improve and streamline the process of managing insanity acquitees who have been conditionally released.

c. Enhance the capacity of CSBs to provide restoration to competency services in jails and community settings.

2. Implement national and state service models that represent best practices in areas such as crisis teams, assessment and diagnostic services, early identification procedures, treatment services, pre-release planning, assertive case management, post-release services, and drug courts.

Action Steps:

a. Incorporate national and state service models into long-range interagency planning activities.

b. Provide training and technical assistance to criminal justice and mental health, mental retardation, and substance abuse services staff on national and state service models.

c. Identify, and where appropriate, implement national and state service models that represent best practices across Virginia.

3. Strengthen state and local collaboration necessary to provide an effective continuum of care for adult and youth offenders with behavioral health service needs.

Action Steps:

a. Continue to collaborate with DCJS, DJJ, and DOC in ongoing strategic planning, policy, and service development efforts.

b. Expand the number of communities that have collaborative mental health and juvenile justice projects.

c. Provide technical assistance to CSBs, jail and detention centers, sheriffs, and courts in the development of local interagency memoranda of agreements that clarify goals, define responsibilities, and outline specific activities and tasks, including procedures for accessing treatment in jails and detention centers and identifying case managers responsible for coordinating continuity of care across the systems.

d. Monitor the status of memoranda of agreement between criminal justice and treatment agencies.

e. Enhance the delivery of behavioral health services to incarcerated individuals to reduce demand for secure forensic treatment and to prevent re-hospitalization of individuals returned to incarceration following inpatient evaluation and treatment.

f. Encourage participation of CSBs on local drug court planning and implementation committees.

g. Provide training in mental illness and substance use disorders to criminal justice professionals and in criminal justice issues to mental health and substance abuse professionals.

4. Provide timely forensic evaluation and treatment services in the most appropriate settings that meet but do not exceed the level of intervention needed to provide necessary treatment and maintain public safety.

Action Steps:

a. Continue to work with CSBs and private providers to expand their capacity to provide forensic evaluation services in the community.

b. Continue to provide training and technical assistance to CSBs to enhance their management of insanity acquittees who have been conditionally released.

c. Support CSB efforts to develop community placement alternatives for individuals found NGRI that provide a higher level of support and services access, thereby decreasing the need for prolonged and more restrictive hospitalization.

d. Continue to explore resources for CSBs to provide community-based restoration to competency to stand trial services to the courts for nonviolent offenders not needing state hospital treatment.

e. Establish sub-acute residential programs for individuals receiving forensic treatment in state facilities who no longer need an inpatient level of services.

f. Continue to streamline and improve the Department's Forensic Review Panel privilege-granting process for state facility forensic patients who meet certain criteria.

5. Develop new and maintain and expand existing treatment opportunities in communities and institutional settings for individuals with substance use disorders who are involved with criminal justice agencies.

Action Steps:

a. Continue to provide technical assistance to CSB services provided in jails and detention centers to adults and juveniles.

b. Seek state funding for innovative programs aimed at jail diversion and improvement of services in local correctional facilities.

Goal 12: Assure that CSBs are aware, prepared, and have sufficient resources to address growing demands among veterans of post-9/11 deployment and current members of the Virginia National Guard.

Objectives:

1. Partner with the Virginia Department of Veterans Services to improve access by Virginia's veterans to behavioral health services and supports.

Action Steps:

a. Work with the Department of Veterans Services and the VA to understand the scope, clinical components, and demand for behavioral health services by Virginia veterans.

b. Develop, in collaboration with the Department of Veterans Services, a state level strategy and protocols for serving veterans with behavioral health issues.

c. Work with the VA to assure that CSBs are aware of the behavioral health needs of veterans residing in their service areas.

d. Work with the VA to provide specialized training for CSB clinicians on the behavioral challenges confronting veterans and their families.

e. Promote the attendance by CSB clinicians at VA seminars and training on PTSD and the behavioral health effects of traumatic injuries.

f. Work in collaboration with the Department of Veterans Services to forecast and prepare for long term care requirements of veterans experiencing progressive effects from traumatic injuries.

g. Determine the additional distribution of capability and capacity required within CSBs.

h Assist the CSBs obtain the resources necessary to provide needed behavioral health services and supports to veterans.

i. Work in collaboration with the Department of Veterans Services to provide transitional housing for veterans with behavioral health challenges.

j. Establish, beginning in FY 2008, pilot efforts in Northern Virginia, Hampton-Newport News, Cumberland Mountain, and Richmond to develop best practices for linking veterans to behavioral health services provided by CSBs.

Goal 13: Provide individualized treatment services in a secure environment to individuals civilly committed to the Department as sexually violent predators.

Objectives:

1. Provide each SVP program resident with access to meaningful and individualized sex offender treatment.

Action Steps:

a. Use Department experts to assist in the design and development of treatment approaches, protocols, and practices for individuals who are civilly committed as sexual violent predators.

b. Continue to offer treatment programs in times and frequencies that are consistent with relevant clinical Departmental Instructions.

c. Provide each resident with access to group and individual therapy, as appropriate.

2. Provide each SVP program resident appropriate access to psychosocial rehabilitation and work activity.

Action Steps:

a. Incorporate national guidelines for rehabilitation, work, and recreation activities in program policies, procedures and activity plans.

b. Use Department rehabilitation experts to assist in the design and development of appropriate work and recreation activities.

3. Offer each SVP program resident the maximum opportunity to develop the self-control necessary for returning to the community.

Action Steps:

a. Provide each resident with access to therapeutic methods designed to reduce interest in abusive sexual themes.

b. Provide each resident with access to therapeutic methods designed to reduce impulsive sexual response to abusive sexual themes.

c. Provide each resident with access to therapeutic methods designed to increase knowledge of, interest in, and sexual attraction to appropriate sexual themes.

4. Complete construction of a new Center for Behavioral Rehabilitation.

Action Steps:

a. Relocate the VCBR to the new SVP treatment facility.

Goal 14: Improve the quality and appropriateness of support and treatment for persons with a diagnosis of co-occurring mental retardation and mental illness.

Objectives:

1. Promote and reinforce collaboration and joint responsibility in the provision, coordination, and oversight of MR/MI services.

Action Steps:

a. Encourage CSBs to assign staff with specific responsibility for helping individuals and families negotiate the entire set of services available to persons with co-occurring MR/MI diagnoses.

b. Work with the CSBs and state facilities to develop and implement regional protocols for serving individuals with co-occurring mental retardation and mental illnesses.

c. Provide opportunities for the families and individuals receiving services to receive education about co-occurring MR/MI and actively participate in treatment planning when an individual is beginning to show signs of decompensation, through the crisis period, and during transition back to the community.

d. Improve the community-based system of supports by expanding the number of staff trained and endorsed in positive behavioral supports.

2. Develop and implement best practice service models in Virginia for persons with a diagnosis of mental retardation and co-occurring mental illness.

Action Steps:

a. Provide joint training for state facility and community administrators, clinicians, and direct care workers aimed at identifying and appropriately responding to the needs of individuals with co-occurring diagnoses of MR/MI, clarifying service responsibilities, and reconciling differences in language, philosophy, and expected outcomes between mental health and mental retardation services providers.

b. Provide technical assistance and training to state facilities and community public and private providers on steps necessary to implement best practices for serving individuals with co-occurring diagnoses of MR/MI.

c. Develop a plan, in collaboration with state facility and public and private community mental health and mental retardation services providers, to implement best practices in community and state facility settings.

Goal 15: Provide appropriate assessments, interventions, and specifically designed programming to persons with co-occurring diagnoses of mental illnesses and substance use disorders.

Objectives:

1. Improve the level of consultation, collaboration, and integration among providers of mental health and substance abuse services around policy, funding, staffing, and programming issues.

Action Steps:

a. As required by the Virginia Service Integration Project (VASIP) grant, continue to develop and coordinate activities of the VASIP State Steering Committee.

b. Provide support to the activities of the Steering Committee and necessary workgroups.

c. Work with the Steering Committee to produce recommendations for policies, funding, data collection, program development, service delivery, training, and staffing.

d. Work with the Steering Committee to make policy, regulatory, and funding recommendations.

e. Maintain a website for the VASIP initiative on the Department's main web site to inform constituencies about VASIP activities.

2. Through the VASIP and SAC grants, strengthen the ability of CSBs to provide specifically designed services for adults and youth with co-occurring diagnoses of mental illnesses and substance use disorders.

Action Steps:

a. Continue to provide technical assistance and consultation to CSBs and state hospital to increase knowledge and skill among administrators, clinicians, and gatekeepers regarding screening and assessment, case management, program design, treatment planning and funding, and data collection as they relate to adults and youth.

b. Promote the concept of Dual Diagnosis Capability in mental health and substance abuse treatment programs at all levels of the services system.

3. As required by the VASIP and SAC grants, establish uniform diagnostic criteria for identifying adults and youth with co-occurring mental illnesses and substance use disorders.

Action Steps:

a. Identify or develop uniform diagnostic criteria to identify persons with co-occurring diagnoses of mental illness and substance use disorders and provide ongoing training, consultation, and technical support for effective knowledge transfer.

Goal 16: Ensure quality and continuity of care for people who are deaf, hard of hearing, late deafened, or deafblind and are in need of mental health, mental retardation, or substance abuse services.

Objectives:

1. Address the identified need for additional resources to meet the service demand of the people who are deaf, hard of hearing, late deafened or deafblind.

Action Steps:

a. Implement strategies to provide additional funding for the existing six regional programs, as supported by the Advisory Council, to be able to provide the intensive services required by this population.

b. Implement strategies to expand statewide services to encompass regions that are currently underserved or not receiving services through the addition of regional coordinators or case managers as dictated by need.

c. Explore with the Advisory Council the need for program enhancements and development of residential services to meet the needs of persons who are deaf, hard of hearing, late deafened, or deafblind.

2. Provide resources and interagency collaboration response to meet the needs of persons who are deaf, hard of hearing, late deafened, or deafblind in receiving mental health, mental retardation, or substance abuse services.

Action Steps:

a. Explore and implement strategies to expand statewide interagency and regional interagency coordination and collaboration.

b. Explore strategies to expand the activities of the State Coordinator's position.

c. Explore strategies to expand the interpreter reimbursement fund.

3. Strengthen existing policies and guidelines at state facilities and CSBs to promote access for persons who are deaf, hard of hearing, late deafened, or deafblind.

Action Steps:

a. Provide technical assistance and guidance on appropriate communication and cultural access to services for persons who are deaf, hard of hearing, late deafened, or deafblind.
b. Continue to explore with the Advisory Council ways that the service system can appropriately refer individuals to culturally competent community and inpatient providers.

Goal 17: Promote and support the implementation of evidence-based practices.

Objectives:

1. Develop shared commitment to adoption of consensus and evidence-based practices across the Department, CSBs, and state facilities.

Action Steps:

a. Obtain state-level technical assistance from SAMHSA's Co-Occurring Center for Excellence on implementation of evidence-based practices, including building consensus for the need for implementing these practices among service providers.
b. Gain advocacy and other services system partners' support for the adoption of evidence-based practices through dialogue with the Mental Health Planning Council, the Governor's Substance Abuse Council, NAMI-VA, MHAV, SAARA, Arc of Virginia, CHBHPPC, and other organizations.
c. Revise existing service definitions to incorporate best practices, where appropriate.
d. Work with services system partners to develop and implement methods to recognize and reward exemplary evidence-based programs that demonstrate positive individual outcomes.
e. Explore the potential for public-academic partnerships to support statewide implementation of best practices by all public sector providers of services.
f. Explore the feasibility of realigning funding to support the delivery of best practices.

2. Provide information and technical and evaluation assistance that supports the use of consensus and evidence-based practices in publicly funded services for persons with substance use disorders.

Action Steps:

a. In partnership with the Mid-Atlantic Addiction Technology Transfer Center, provide regional training to public providers that will assist practitioners in identifying and selecting appropriate consensus and evidence-based practices.
b. Continue to provide onsite technical assistance to CSBs to develop, implement, and evaluate evidence-based practices.
c. Continue to work with the SA Council of the VACSB to develop core standards for substance abuse services based on evidence-based practices.
d. Continue to increase awareness of scientific advances that have implications for treatment.

3. Support development and adoption of evidence-based practices for persons with co-occurring MI/MR disorders.

Action Steps:

a. Support Regional Community Support Centers' provision of evidence-based practices.
b. Support the Mid-Atlantic Technology Transfer Center's efforts regarding evidence-based practice knowledge dissemination and technology transfer and explore opportunities for additional collaboration.

4. Increase the number of evidence-based prevention programs for youth and families that address the risk factors of availability of drugs, family management problems, and early alcohol, tobacco, and other drug use.

Action Steps:

a. Provide support and technical assistance in the selection, implementation, and evaluation of evidence-based prevention programs for youth and families.

b. Monitor CSB provision of evidenced-based prevention programs through the prevention database.

c. Develop, publish, and distribute the *Directory of Virginia Prevention Researchers and Evaluators*, a resource guide for training and evaluation services in Virginia.

d. Make available evidence-based prevention program materials and evaluation instruments through the prevention database and mail distribution.

e. Support the development and recognition of Virginia prevention programs as model programs.

5. Provide training in evidence-based clinical practices to CSB and state facility physicians and other treatment professionals.

Action Steps:

a. Develop two centers of excellence in partnership with Virginia universities to provide workforce and program development, training, and consultation system wide.

b. Host a series of training programs and symposia for community and state facility practitioners that feature national experts on the topic of evidence-based practices.

c. Disseminate literature on the practice and benefits of evidence-based medicine to community and state facility medical directors at regularly scheduled meetings.

d. Disseminate available evidence-based practices and clinical guidelines to practitioners in community and state facility programs.

e. Identify and feature practitioners in the public system and private practice who are using evidence-based practices as speakers at meetings, training programs, and symposia.

f. Establish mechanisms for the sharing of information about evidence-based practices between community and facility psychiatrists an in the public and private sectors.

g. Periodically evaluate the utilization of evidence-based practices in community and state facility programs.

6. Develop the capacity to train, credential, and compensate professionals who can offer Positive Behavioral Support (PBS) services.

Action Steps:

a. Continue to sponsor training to increase the number of individuals endorsed in PBS.

Goal 18: Assure that state hospitals and training centers provide quality assessment, treatment, rehabilitation, training, and habilitation services that are appropriate to the needs of individual patients and residents.

Objectives:

1. Offer a comprehensive array of person-centered treatment, rehabilitation, habilitation, and training services that promote self-determination, recovery and resilience, and community participation.

Action Steps:

a. Maintain sufficient numbers of trained staff in each state hospital and training center to ensure services are appropriate to the population served and sufficient to provide quality services and consumer safety.
b. Encourage state hospitals to incorporate and implement strategies such as peer-to-peer supports; computer and Internet access; and educational, career development, and job training opportunities in their comprehensive recovery plans.
c. Develop and implement strategies in each training center that facilitate person-centered planning and promote self-determination and community participation.
d. Encourage all state facilities to implement wellness programs with activities designed to lower obesity, hypertension, diabetes and heart disease and to facilitate exercise and other health lifestyle choices.
e. Improve bed utilization in state hospitals through the provision of aggressive treatment and discharge efforts that reduce lengths of stay and enable consumers to be integrated more quickly into the community.
f. Expand the capacity of training centers to provide more intensive services for residents with co-occurring mental retardation and challenging behaviors and expand their behavioral management teams.
g. Expand the scope and depth of Regional Community Support Centers statewide.
h. Develop strategies to provide state facility specialized medical and clinical staff for treatment and consultation services to CSBs.
i. Use state facility medical and clinical specialists to provide training to CSB personnel in identified areas of need in areas of need such as geriatric medicine, child psychiatry, psycho-pharmacology, forensic psychiatry, and applied behavior analysis, using interactive telecommunication networks and video technology.
j. Support the efforts of the OIG to monitor the progress of state facilities in improving quality of care.

Goal 19: Ensure that CSB prevention services address risk and protective factors and service gaps identified by community-based prevention planning coalitions.

Objectives:

1. Continue and strengthen the ability of community-based prevention planning coalitions to engage in an on-going prevention planning process and to select, implement, and evaluate evidenced based prevention programs that address prioritized risk factors.

Action Steps:

a. Increase support for community-based planning for prevention services by collaborating with other federal and state systems and participating in national and state organizations focusing on prevention.
b. Provide risk indicator data through the statewide youth survey, social indicator data bank, and Synar Inspection Report to community prevention planning groups for their identification of the most salient risk factors and problem adolescent behaviors.
c. Work with the Virginia Tobacco Settlement Foundation to administer a statewide youth survey process.
d. Review annually CSB prevention services plans provided by the Performance-Based Prevention Services data and written reports to ensure that prevention services address prioritized risk factors, are evidence-based, and are supported by collaborative and complementary services of other systems and groups.
e. Provide information and training on methodology and opportunities for collaborative prevention efforts.

2. *Increase opportunities to plan and implement prevention services at the state and local level.*

Action Steps:

a. Share training, technical assistance, and planning resources with a variety of agencies and organizations invested in reducing substance abuse and dependence.

b. Continue to build collaborative relationships at the state level and encourage and support collaboration at the local level to enhance environmental change and implement strategies that reduce exposure to risk and enhance protective factors.

Goal 20: Reduce the incidence and prevalence of suicide among youth and adults in Virginia.

Objectives:

1. Expand suicide prevention training and awareness activities targeted to youth and adults.

Action Steps:

a. Initiate implementation of the *Suicide Prevention Across the Lifespan Plan for the Commonwealth of Virginia*.

Goal 21: Continue to reduce youth access to tobacco products.

Objectives:

1. Continue to emphasize reduction of youth access to tobacco products as a legitimate prevention issue related to reduction of drug and alcohol abuse and improved health outcomes.

Action Steps:

a. Continue to educate youth about the harmful effects of tobacco use.

b. Encourage support by the Virginia Tobacco Settlement Foundation of efforts to reduce youth access to tobacco products.

c. Continue to support tobacco specific prevention strategies and activities.

d. Develop a strategic prevention focus on regions reporting highest noncompliance.

e. Continue to measure noncompliance in accord with the Synar Amendment.

Goal 22: Enable Virginia's mental health, mental retardation, and substance abuse services system to better understand and prepare for the heightened threat potential facing the Commonwealth.

Objectives:

1. Provide training to all CSBs and state facilities in crisis counseling and all hazards disaster response.

Action Steps:

a. Support CSBs efforts to develop, refine, and exercise their all-hazards emergency response plans and secure additional disaster training.

b. Promote the involvement of state facilities in Virginia Hospital and Healthcare Association's regional hospital emergency preparedness councils.

c. Provide training in a variety of disaster behavioral health interventions in order to increase and improve the capability of the Virginia public behavioral health system to respond to any type of disaster.

d. Provide training in crisis counseling program intervention basics and grant development to all CSBs.

Goal 23: Establish structures and relationships that will assure an immediate, effective, and coordinated response to terrorism-related and other major disasters by the mental health, mental retardation, and substance abuse services system.

Objectives:

1. Link CSBs, state and private facilities, school systems, public health departments, faith communities, professional organizations, academic institutions, and others into planning and response to disasters and terrorism–related events.

Action Steps:

a. Develop formal memoranda of understanding between contiguous CSBs to provide mutual support and response to disasters.

b. Encourage and assist CSBs to develop strong supportive working relationships with other local mental health and substance abuse providers and first responders.

c. Continue to provide train-the-trainer workshops that enable all CSBs and state facilities to directly train local response partners in disaster behavioral health.

d. Continue development of regional state facility evacuation plans.

e. Assure that all state mental health and mental retardation facility disaster plans meet Joint Commission on the Accreditation of Healthcare Organizations standards.

2. Improve services system disaster response infrastructure and communication capabilities.

Action Steps:

a. Provide disaster preparedness and recovery training, assistance, and support to state facilities and CSBs.

b. Provide funding to support additional emergency response equipment for CSBs.

D. Partnerships for Services System Transformation

State-Level Partnerships

Over the past six years, the Department has worked to strengthen its partnerships with a number of state agencies, including DMAS, DRS, the Department of Housing and Community Development (DHCD), the Department of Social Services (DSS), the Department for the Aging (VDA), the Department of Education (DOE), the Department of Corrections (DOC), the Department of Criminal Justice Services (DCJS), the Department of Juvenile Justice (DJJ), the Virginia Department of Health (VDH), the Virginia Employment Commission (VEC), and the Virginia Housing Development Authority (VHDA). These partnerships are essential because the needs and challenges experienced by Virginians with mental illnesses, mental retardation, or substance use disorders extend beyond the public mental health, mental retardation, and substance abuse services system. Many agency representatives participate as members of a variety of state and regional system transformation activities, including the Regional Planning Partnerships, The Advisory Consortium on Intellectual Disabilities (TACID), and the special populations workgroups. A brief overview of Departmental activities involving these partners follows.

Medicaid: The Report of the President's New Freedom Commission on Mental Health, *Achieving the Promise,* indicates that states have relied heavily on financial support from the Federal Government for their mental health systems and, as a result, Medicaid is now the single largest payer of mental health services in the country (page 21). This is also true in Virginia; Medicaid is by far the largest single source of funds for community services across the state.

The increasing prominence of Medicaid funding in CSB budgets has emphasized the importance of interagency collaboration in policy development, provider development, education and training of providers, development of quality assurance measures, and provider oversight. Virginia needs to take advantage of opportunities used by many other states to expand critically needed services that could be covered under Medicaid and to align existing services to recovery, resilience, and person-centered principles and practices. The Department plays an important policy input role in exploring and implementing Medicaid initiatives in Virginia. The recent expansion of Medicaid coverage for substance abuse services, enacted by the 2007 General Assembly, is an example of this interagency partnership. The Department also has been involved in the expansion of community rehabilitation services to include co-occurring mental health and substance abuse treatment and in the successful application for a child and adolescent Alternatives to Psychiatric Residential Treatment demonstration waiver.

Social Services: The Department works closely with DSS in a variety of programs and services that help individuals cope and recover from the effects of poverty, abuse, and neglect and achieve self-sufficiency. Several areas of collaboration include services to families who are TANF recipients, services to families confronting child custody issues, and services to substance-exposed infants and their families.

Housing: The Department has a long history of collaborative linkages and partnerships with VHDA, DHCD, the Disability Commission's Housing Workgroup, the Virginia Inter-Agency Council on Homelessness (VIACH), CSBs, and public and private housing providers to promote, enhance, and develop housing opportunities for individuals receiving mental health and substance abuse services. The Department also supports PATH outreach and engagement activities for individuals with mental illnesses who are homeless and recovery-focused housing alternatives, such as Oxford Houses, for individuals with substance use disorders.

Virginia has been selected for a Money Follows the Person Demonstration pilot, which provides enhanced federal Medicaid matching funds for a 12 month period to transition individuals with disabilities and older adults from institution to residences in the community. The Department will work closely with multiple state agencies and private organizations to implement this important effort.

An innovative and special savings program, the Virginia Individual Development Account (VIDA) Program, administered by DHCD in conjunction with DSS, exists to help eligible individuals gain financial literacy skills and build assets. For every dollar the participant saves in a designated account, VIDA matches it with two dollars. For individuals with mental illness, poverty is one of the most pervasive, significant, and debilitating barriers to achieving maximum participation in the community and recovery. People with mental illness too often live in substandard housing, lack opportunities for meaningful activity and daily structure, have limited social and recreational resources, have difficulty gaining access to quality health care, and experience alienation and loneliness. The VIAD asset-building and financial self-management service model has the potential to affect recovery, self-sufficiency, and community integration for people with mental illness. The Department intends to work with DHCD and DSS to expand this program to more broadly target individuals with mental illness to affect systems change.

Primary Health Care: There are a number of published studies showing that individuals with serious mental illness have higher rates of physical disability, significantly poorer health, and higher mortality rates than the general population. Physical health care is considered a core component of basic services for individuals with mental illness, mental retardation, or substance use disorders although this care is often fragmented in the community for these individuals. However, there is an increasing professional recognition of the essential interconnection between physical and behavioral health and keen interest in finding ways to link physical and behavioral systems of care (NASMHPD, 2005). It is critical that individuals receiving services in the public mental health, mental retardation and substance abuse service system are screened, assessed, and treated as necessary for physical health issues.

The Department and the CSBs maintain partnerships with appropriate agencies and entities including the Department of Health, the Virginia Primary Care Association, the Virginia Rural Health Resource Center, the Virginia Hospital and Healthcare Association, the Virginia College of Emergency Physicians and the Virginia Association of Free Clinics. Through these collaborative efforts guidance materials and other protocols have been developed to assist clinicians and direct service workers to recognize signs of physical health problems in individuals with behavioral health issues and improve coordination between mental health, mental retardation, and substance abuse care and primary health care.

Employment Services and Supports: Adults with a serious mental illness and youth with serious emotional disturbances face challenging obstacles to obtaining and maintaining competitive employment. This is also true for individuals with mental retardation and substance use disorders. Pervasive stigma, the limited availability of the evidence based practice of supported employment, fear of losing health insurance coverage, complicated funding streams, and poorly coordinated vocational assistance programs are some of the many factors that overwhelm individuals attempting to secure employment or employment services. Joint mental health and substance abuse employment initiatives between the Department and DRS provide specialized vocational assistance services in CSBs. A multi-agency initiative involving the Department, DMAS, DRS, and the academic community has further developed a Virginia-specific WorkWORLD^{TM} decision support software designed to support people with disabilities who are making decisions about gainful work activity and the use of work incentives. The Department will examine the feasibility of using this decision support software to expand training on Social Security work incentives.

***Criminal Justice and Juvenile Justice Service*s:** In too many cases, the criminal justice system has become the primary source for mental health care. In ongoing efforts to improve screening, ensure appropriate treatment and supports, and enhance interagency planning and coordination to better meet the needs of individuals involved with the criminal justice system, the Department maintains strong working relationships with DOC, DJJ, and DCJS. DOC works closely with the Department to improve access to hospital and community treatment resources that have been released from DOC facilities and screens inmates who are potentially eligible for civil commitment to the Department as sexually violent predators. DCJS has partnered with the Department to develop and implement cross training in mental health evaluation and treatment methods for law enforcement personnel, including jail security staff.

The Department and DJJ have collaborated on an initiative, originally supported with federal funds but now supported by state funds, to support mental health case management services provided by CSBs in regional juvenile detention centers. CSBs are now providing short-term behavioral health services to children in 23 of the 25 juvenile detention centers.

Advocacy: Department central office and state facility staff work with the Virginia Office for Protection and Advocacy (VOPA) to ensure protections and advocacy for the human and legal rights of individuals with mental, cognitive, or developmental disabilities.

Local Interagency Partnerships

At the local level, these critical partnerships include school systems, social services, local health departments, and area agencies on aging. Services provided by these local agencies are critical to the success of individuals with mental illnesses, mental retardation, and substance use disorders, including Medicaid MH and rehabilitation services, MR waiver services, auxiliary grants for assisted living facilities, Medicaid eligibility determinations, various social services, guardianship programs, health care, vocational training, housing assistance and services for TANF recipients. Some local agencies also participate on Part C local interagency coordinating councils and provide Part C services to infants and toddlers.

Partnerships with Private Providers

The private sector is a vital partner with CSBs in serving people with mental illnesses, intellectual disabilities, or substance use disorders. In addition to serving many individuals through contracts with CSBs, private providers also serve other individuals directly, for example, through various Medicaid programs such as the MR waiver (with plans of care managed by CSBs) and mental health and inpatient psychiatric treatment services. Private provider participation in the services system is another major strength of the public mental health, mental retardation, and substance abuse services system. This participation has grown dramatically over the last six years. This continued expansion of MR waiver services has been a major factor influencing this growth.

Despite this significant expansion, two limiting phenomena have been apparent in this process: the absence of private providers in certain parts of the state and the need for private providers to offer more of particular types of services. Consequently, the development of private providers needs to be fostered and supported in various parts of the state. This includes encouraging existing private providers to expand their operations to other parts of the state, to begin offering other services, and to increase their current capacities. This also includes identifying and, where possible, offering incentives to promote the development of new private providers. These initiatives should be joint efforts by the Department and CSBs, working closely with the private provider community.

A number of conditions have limited, reduced or jeopardized private provider participation in the publicly funded mental health, mental retardation, and substance abuse services system.

- While Medicaid State Plan Option (SPO) rehabilitation services and home and community-based waiver reimbursement rates have been increased slightly in recent years, many rates still need to be increase more. In some areas of the state, Medicaid fees reportedly do not cover the cost of providing services; consequently, private providers are not able to offer those services on an economically sustainable basis.
- Third party insurance coverage for services continues to decline under managed health care, in terms of services covered, amounts of services allowed, and amounts paid for services.
- A growing proportion of individuals have inadequate or no health insurance coverage.
- Information about potential private providers may not be readily available to CSBs when their staffs are developing individualized services plans.
- There is a perceived or actual resistance by some private providers, especially residential or inpatient providers, to serving individuals receiving CSB services, because of the severity of the individuals' disabilities or lack on information about effective treatment modalities.
- Market forces have led to shifts in private sector service provision, despite the obvious and significant public sector needs for particular services. A clear and immediate example of this condition is the marked and continuing reduction in local private psychiatric inpatient hospital beds in some parts of the state that are available to CSBs and the Department. Some providers have ceased offering this service due to inadequate reimbursement rates; others have converted their inpatient beds to other uses, such as Comprehensive Services Act residential beds, which may be less costly to operate and more easily reimbursable. Additionally, some MR waiver residential providers have converted to ICF/MRs due to low Waiver reimbursement rates.
- Like public providers, the private sector is experiencing increasing difficulties in recruiting and retaining qualified staff, including professionals, such as nurses and other clinical staff, and para-professionals, such as residential aides and personal care staff.

- The large capital cost sometimes associated with the implementation of new services, particularly residential services, may inhibit private sector participation.
- Finally, the significant start up costs, such as staff recruitment and training, equipment purchases, acquisition of space, and operating at less than full capacity during implementation that are often required to initiate a new service may make it difficult for smaller providers to do so, limiting their participation in the publicly-funded services system.

Partnerships with Community Services Boards and Local Governments

The Department took a new approach in developing the FY 2004 Community Services Performance Contract. In collaboration with CSB representatives, Department staff developed the new contract from a blank slate, rather than just revising the previous year's contract. This produced a greatly shortened and more focused FY 2004 Performance Contract. It also produced two new documents, the *Partnership Agreement* and the *Community Services Contract General Requirements Document* and a new document, the *Central Office, State Facility, and Community Services Board Partnership Agreement*. The Department and CSBs have continued this very effective and productive approach in successive fiscal years.

The Partnership Agreement describes the values, roles, and responsibilities of the three operational partners in the public mental health, mental retardation, and substance abuse services system: CSBs, state facilities, and the Department's central office. It reflects the fundamental, positive evolution in the relationship between CSBs and the Department to a more collegial partnership. It recognizes the unique and complementary roles and responsibilities of the Department and the CSBs as the state and local authorities for the public mental health, mental retardation, and substance abuse services system. The goal of the agreement is to establish a fully collaborative partnership process through which the CSBs, central office, and state facilities can reach agreements on operational and policy matters and issues.

The partners entered into the agreement to improve the quality of care provided to individuals and to enhance the quality of individuals' lives. While they are interdependent, each partner works independently with both shared and distinct points of accountability, such as state, local, or federal government, other funding sources, individuals, and families, and all partners embrace common core values.

The 134 cities or counties in Virginia continue to be vital members of the state-local partnership that enables the provision of community mental health, mental retardation, and substance abuse services to more than 198,000 Virginians annually. Local governments partner with the Commonwealth through the CSBs that they established and maintain and through their financial and other support of services offered by those CSBs. The Department needs to continue communicating with local governments through their CSBs about their concerns and ideas, such as ways to enhance service quality, effectiveness, and efficiency. As demands for services continue to exceed the capacity of the current services system to meet them and as related requirements for more effective management and coordination of services proliferate, new and innovative approaches need to be considered that preserve the strengths and advantages of the current public services system and the state-local partnership, while responding to these new demands.

System Leadership Council

The System Leadership Council evolved from the FY 2001 community services performance contract negotiations, reflecting a desire to include a mechanism in the contract for providing continuity, enhancing communication, and addressing systemic issues and concerns. Based on that contract, the Department established the System Leadership Council in August 2000. The Council includes representatives of the CSBs, state facilities, local governments, local hospitals,

mental health service consumers, mental retardation and substance abuse service advocacy organizations, private providers, regional jails, the State Board, and the Department's central office.

The Council continues to serve as a coordinating mechanism to discuss issues and problems from a systemic point of view, providing continuity, enhanced communication, and a consistent perspective over time. The Council's work and recommendations affect the organization and delivery of publicly funded services in Virginia. The Council continues to discuss a broad range of issues and support various initiatives, including performance contract and reporting requirements, workforce concerns, pharmacy and medication issues, discharge protocols, and inpatient utilization review and management. In recent years, the Council has focused on reinvestment and restructuring activities and the system transformation initiative, plus the Integrated Strategic Plan that will guide this initiative.

In 2005, the Council reaffirmed its focus on long-term, strategic issues and concerns. To address more immediate issues, the System Operations Team was established. The team coordinates the service's system's response to programmatic and operational issues and acts as a problem-solving group. The team includes Department, CSB, and state facility staff.

Goals, Objectives, and Action Steps

Goal 24: Realize cost savings to the Commonwealth by expanding Medicaid funding for community mental health, mental retardation, and substance abuse services.

Objectives:

1. Align Medicaid mental health, mental retardation, and substance abuse services with recovery and resilience principles and practices and expand opportunities for individual and family participation in individual-directed services.

Action Steps:

a. Maximize opportunities to incorporate recovery, resilience, and person-centered practices into targeted case management and state plan option service definitions through changes in the Medicaid provider manuals.

b. Maximize opportunities within the State Medicaid Assistance Plan to provide Medicaid-coverage for peer provider and consumer-run services.

c. Work with DMAS and CSBs to implement substance abuse treatment services.

d. Work with DMAS to revise the MR waiver to increase flexibility and address issues with the current waiver (e.g. coverage for general supervision).

e. Continue the Department's participation in the development of Medicaid procedures and regulations that affect behavioral health.

f. Continue to work with DMAS to ensure providers receive appropriate training and communications regarding approved substance abuse treatment services (e.g., services for pregnant and postpartum women and adolescent substance abuse treatment through EPSDT).

g. Increase utilization of state plan option services to provide rehabilitation services for persons with co-occurring MI/SUD disorders.

h. Transfer management of the Involuntary Commitment Funds from DMAS to the Department to increase the effective management of local inpatient psychiatric hospital beds for temporary detention orders.

i. Collaborate with DMAS and other state and private partners in implementing the System Transformation Grant initiative.

Goal 25: Increase the stability of families affected by mental illnesses and substance use disorders that are receiving TANF benefits or are involved in protective services.

Objectives:

***1. Provide mental health and substance abuse services to families involved in TANF, ASFA, or in other social services initiatives*.**

Action Steps:

a. Improve identification and assessment strategies.

b. Improve matching of individual needs to service type, intensity, and length of treatment.

c. Expand opportunities for cross-training and other methods of technology transfer.

d. Utilize the interagency Safe Families in Recovery Strategic Plan and Memorandum of Understanding to facilitate planning and collaboration.

Goal 26: Provide safe and affordable housing that meets the needs of individuals receiving mental health, mental retardation, or substance abuse services.

Objectives:

1. Expand safe and affordable housing alternatives.

Action Steps:

a. Provide ongoing assistance to CSBs and publicly funded services providers in accessing federal resources to meet the housing and community-based supports needs of individuals receiving services.

b. Work with DHCD and DSS to explore strategies to expand the Virginia Individual Development Accounts programs to individuals with mental illness.

c. Collaborate with state and private partners in the Money Follows the Person demonstration grant.

d. Work with the VHDA, DHCD, and other agencies to maximize the use of all available housing resources and collaborate with them to design and implement affordable housing development plans for the benefit of low-income and homeless Virginians with mental disabilities.

e. Continue to meet with VHDA, DHCD, CSBs, centers for independent living, disability services boards, and area agencies on aging to understand local and regional housing needs and strategies and priorities for state resources.

f. Continue to provide information to CSBs about grants and other funding opportunities that provide resources to meet housing needs.

2. Provide safe, substance-free, affordable housing to persons in recovery through existing and new Oxford Houses.

Action Steps:

a. Contract with Oxford House, Inc. or a similar organization to provide loan management services and technical assistance to individual Oxford Houses.

b. Provide technical support to existing Oxford Houses and to communities interested in establishing and collaborating with Oxford Houses.

c. Continue to support the loan fund.

d. Continue to establish relationships with individual Oxford Houses.

e. Encourage networking among established Oxford Houses.

Goal 27: Improve the physical health and wellness of individuals receiving mental health, mental retardation, or substance abuse services.

Objectives:

1. ***Support and expand partnerships between providers of physical health and mental health, mental retardation, or substance abuse services.***

   Action Steps:

   a. Provide training and education to state facility and community psychiatrists aimed at increasing their awareness of potential severe side effects, such as heart disease and diabetes, of the new anti-psychotic and other medications.

   b. Support the development of formal agreements and cross-referral networks between CSBs and free clinics, federally funded health centers, and other providers of primary care services.

   c. Encourage state facilities and CSBs to consider wellness strategies in individuals' service planning.

2. ***Improve the identification, screening, and diagnosis of substance use disorders and referrals to services by providers of primary health care services.***

   Action Steps:

   a. Continue to seek resources and collaborative partners for technology transfer to providers of primary health care services.

   b. Continue to refine and revise "packaged" materials, such as the Substance Abuse Toolbox.

   c. Develop multi-media, multi-staged approaches to education primary care providers.

Goal 28: Reduce barriers to employment for youth and adults with mental disabilities.

Objectives:

1. ***Increase access of individuals, family members, case managers, and public and private vocational and employment-related services providers to accurate information on existing SSI and SSDI work incentives.***

   Action Steps:

   a. Strengthen the linkages to and utilization by individuals receiving mental health services, CSB case managers, and community support and psychosocial rehabilitation services staff to SSA benefits planning, assistance, and outreach providers and individualized benefits assistance planning.

2. ***Address the fears of individuals receiving services about the loss of health insurance and prescription coverage if earned income exceeds benefit thresholds.***

   Action Steps:

   a. Continue to work with DSS, DRS, and DMAS to increase utilization of continual Medicaid coverage for individuals on 1619 (b) status with the Social Security Administration.

   b. Continue to disseminate information, provide resources, and draft letters for use by individuals and case managers to assure continuation of Medicaid coverage as allowed by section 1619 (b) when individuals' earned income exceeds SSI thresholds.

   c. Continue to collaborate with the Disability Commission, DRS, DMAS, mental health constituency groups, and others in the development of a Medicaid Works initiative.

   d. Continue to promote widespread utilization of Virginia's customized WorkWORLD™ Software by employment services providers.

Goal 29: Improve competitive employment opportunities and outcomes for individuals receiving mental health, mental retardation, or substance abuse services.

Objectives:

1. ***Improve knowledge about evidence-based employment practices for youth with serious emotional disturbances and adults with serious emotional mental illness.***

   Action Steps:

   a. Provide mental health community support, psychosocial rehabilitation, vocational, PACT, and other providers with information and knowledge on approaches to supported employment and the individualized placement and supports model of employment services.

   b. Link mental health providers with existing Internet web-based instruction and courses on supported employment principles, services, and supports.

   c. Disseminate the *Evidence-Based Practices Supported Employment Implementation Resource Kit* to public and private community mental health support services providers, DRS, and other entities as appropriate.

2. ***Expand the availability of evidence-based supported employment services and supports for youth with serious emotional disturbances and adults with serious emotional mental illness.***

   Action Steps:

   a. Address inter-agency financial and organizational barriers to implementing evidence-based practices of supported employment for adults with serious mental illness.

   b. Encourage state agencies and others to clearly identify and articulate employment-related services and supports that can be supported by each state agency's respective funding streams and subsequently plan, develop, and implement joint training initiatives on this for individuals, family members, and providers.

   c. Collaborate with DMAS to clarify for providers that Virginia's Medicaid rehabilitation services policy allows support services to be provided in the workplace in accordance with CMS and CMHS recognized evidence-based practice of supported employment for persons with mental illness.

   d. Strengthen the emphasis on vocational and employment services and supports for individuals with a mental illness prior to discharge from a state hospital to the community and for all youth and adults with mental disabilities at intake to community mental health programs.

   e. Continue to identify and, as appropriate, collaborate with DRS and other entities on federal and other grant applications that present opportunities for enhancing employment services, supports, and outcomes for young adults and individuals with a serious mental illness.

   f. Continue collaborative efforts with DRS to increase access to vocational services, job training, and rehabilitation for individuals with mental disabilities, including cross-training initiatives for respective staff.

3. ***Expand the interagency agreement between the Department and DRS to include more CSB vocational assistance service sites for individuals receiving substance abuse treatment services.***

   Action Steps:

   a. In collaboration with DRS, evaluate the impact of the agreement on employment, employment stability, and clinical outcomes.

   b. Continue to provide technical assistance to CSBs participating in the agreement.

   c. Continue to provide technical assistance and training to DRS counselors providing services through the agreement.

   d. Enhance services as indicated by evaluation data.

Goal 30: Encourage and facilitate greater private provider participation in the public mental health, mental retardation, and substance abuse services system.

Objectives:

1. Identify ways to increase the number of private providers participating in the publicly managed services system and to expand the array of services they offer.

Action Steps:

a. Increase service availability and encourage greater private sector participation in the publicly funded services system through support of DMAS efforts to increase current reimbursement rates for Medicaid SPO rehabilitation and MR waiver services.

b. Work with DMAS to identify and implement collaborative inter-agency strategies for ensuring client access to qualified providers and behavioral health services that are sufficient in amount, duration, and scope.

c. Continue to work with all affected partners (e.g., CSBs, the Virginia Hospital and Healthcare Association, health planning agencies, individuals, families, and advocacy groups) to identify and implement regional and statewide strategies for ensuring the availability of an adequate number of local acute psychiatric beds and appropriate alternatives that could serve individuals in need of acute psychiatric services in their communities.

d. Continue to work with CSBs and private providers to address workforce issues affecting the availability of adequate numbers of quality staff in community services.

e. Ensure that funding requests contain sufficient provisions for necessary start-up expenses (e.g., staff recruitment and training, equipment purchases, acquisition of space, and operating at less than full capacity during the implementation phase) and for maintaining services after they are implemented (e.g., salary increases and inflation adjustments).

E. Infrastructure and Technology

State Facility Capital Issues and Priorities

State hospitals and training centers continue to be essential components of Virginia's publicly funded services system. The Department is committed to achieving a best practices balance between community and state facility services. As part of that balance, the Department must ensure that state facilities are safe, efficient, well maintained, and appropriately designed to meet the needs of both the services providers and recipients.

The Department operates 16 facilities located in 12 geographic areas. These facilities are comprised of 412 buildings encompassing about 6.5 million square feet with an average age of 49 years and a median age of 55 years. Maintenance and renovation funding has not been adequate to prevent a gradual decline in the condition of these buildings or to allow renovations to meet current treatment and code requirements. Most buildings are in generally poor condition and replacement of major building systems and life safety improvements are needed.

Over the past decade, facility census, programs, and individual client profiles have changed dramatically. The majority of residents are functioning at severe and profound levels of mental retardation. Many residents are non-ambulatory, with multiple, complex medical conditions that require specialized wheelchairs and adaptive equipment. In addition, training centers are experiencing a growing demand to serve individuals with mild or moderate mental retardation who exhibit challenging behaviors that require highly specialized behavioral interventions.

A commensurate change in state facility physical plants has not occurred. Many occupied building are not longer appropriate for the needs of the facility programs and clients. The result

is that many of these buildings are inefficient to operate. Where previously there was a need for a multi-building campus setting, opportunities now exist to provide mental health services within a single building at a greatly reduced cost. State training centers also need to be redesigned to provide a less restrictive, more homelike environment to serve individuals with the most severe and profound disabilities and those with behavioral challenges that make it difficult to find community placements.

Existing facility living areas that are to remain in use must be brought up to current life safety and code standards. Major issues to be addressed in this arena include replacement of fire alarm systems, installation of fire sprinkler systems, appropriate emergency egress, hurricane hardening, and increased numbers of bathrooms. Major renovations are needed to bring buildings into compliance with current codes and certification requirements.

The Department is implementing three facility replacement projects, all procured through the Public-Private Education and Infrastructure Act of 2002 (PPEA). Projects descriptions follow:

- Replacement of the Hancock Geriatric Treatment Center at Eastern State Hospital - This new 150-bed replacement facility, is under construction. Its completion is scheduled for March 2008.
- Replacement of Eastern State Hospital's adult mental health programs - This project to replace the hospital's adult mental health programs is currently in the design phase. The new 150-bed facility will be constructed by the same team that is working on the Hancock Geriatric Treatment Center. It is scheduled for occupancy in the first quarter of 2010.
- Expansion of the SVP Program in Burkeville - This 300-bed facility for the treatment of individuals committed to the Department as sexually violent predators is currently under construction. Construction is on schedule, with completion of the first 100 beds scheduled for January 2008. The last 200 beds will be completed approximately 14 months later.

The Department has received two PPEA proposals for the replacement of Western State Hospital in Staunton, Virginia. Using planning funds provided by the General Assembly, the Department is working with the firm of HDR to establish evaluation criteria and to determine requirements and standards for the proposed replacement facility. It is anticipated that the Department will request approval to enter into Comprehensive Agreement during the 2008 session of the General Assembly.

The Department's Proposed Capital Improvement Plan has two essential components. The first proposes projects necessary to keep operational buildings in use for the next three biennia, including roof, utility, HVAC, and food service repairs, and environmental hazard abatement. The second component is a phased program of facility replacements.

Training centers that do not meet code requirements and are not appropriately configured to meet the needs of their current populations would be replaced with new or renovated facilities Training centers also would provide community support for medical, dental, vocational, speech, occupational and physical therapy, rehabilitation engineering, and staff development and training in the community residential programs. Appendix G provides a listing of the Department's proposed capital priorities for 2008-2014.

Information Technology Issues and Priorities

The Department's information technology resources continue to face challenges brought about by the transitioning of agency staff to VITA (September 2004) and the subsequent partnership between VITA and Northrop-Grumman (July 2006) to support the Commonwealth's technology infrastructure. Supporting out-of-scope services in the 16 state facilities continues to be difficult. The Department maintains 24 production application information technology systems, among them:

- The state facility information system (AVATAR), purchased in 2003 to ensure compliance with the federal Health Insurance Portability and Accountability Act (HIPAA) Transaction and Code Sets Privacy Rule, is in production and producing monthly reimbursement billing.
- The Department, in partnership with the CSBs, is utilizing the Community Consumer Submission (CCS) application, which enables the Department to comply with federal and state reporting requirements. The software is being rewritten to incorporate new reporting requirements, streamline the data acquisition and processing procedures, and utilize data warehousing technologies. It is on schedule to be completed in the autumn of 2007.
- The agency financial application, FMS continues to provide comprehensive budget and financial management information for the Department. The migration to a new technology platform was completed in June 2006.
- The Department's Part C program utilizes the ITOTS application to obtain individual child data that enables local providers to better manage clinician caseloads and meet federal and state reporting requirements. The Department successfully developed and moved the ITOTS application from a third party software vendor to a web-based Department application between July 2006 and February 2007.

The Department's technology environment and staff continue transitioning from supporting legacy applications using older technologies to developing and supporting new applications using current technology. This effort has taken longer than desired due to staffing constraints and competing priorities but progress is being made. By the end of 2007, all data will be migrated from the legacy PRAIS application to SQL Server and new interfaces and reports will be created to permit the Department to save over $280,000 per year in support charges. The Department continues to explore opportunities for standardization of applications development tools. Projects have been initiated to evaluate moving the agency's human rights (CHRIS), seclusion and restraint, forensic information system (FMIS), and PRAIS applications to web-based technologies. The Department also is participating in the multi-agency Medicaid transformation grant that may lead to development of a web-based solution for MR waiver application data.

The Department's technology team complies with Commonwealth of Virginia (COV) application development and project management standards. In addition, change management procedures have been developed and adopted by the development team. Adopting new standards and procedures has required significant changes for both the customers and developers but is providing a considerably more stable and reliable technology environment.

The VITA/Northrop-Grumman Partnership presents strategic and operational challenges and opportunities to the agency. The challenges include ongoing operational support issues, order and procurement processing, delays in delivering solutions for expanded services, staff communications and significant (unanticipated) service cost increases. Despite efforts by VITA and Northrop-Grumman, numerous problems continue in all of these areas. The major goals of VITA transformation – desktop/laptop standardization, centralization of Help Desk functions, server consolidation, and messaging, network, security, data center and voice and video investments – remain the potential benefits of this Partnership. When these goals are implemented, many of the long-standing technology deficiencies affecting the Department should be addressed.

IT security remains a high priority for the agency. New and updated security standards of the Commonwealth combined with HIPAA will require that the agency devote attention and resources to providing adequate safeguards and controls for our technology environment and data. The following standards and directives impact the IT Security initiatives:

- VITA Security Standards 501-01
- VITA Data Protection Standard 507-00

- VITA IT Security Audit Standard SEC502-00
- Comptroller's Directive 1-07 (ARMICS)

A number of external requirements are affecting the Department's information technology capability, including:

- Federal reporting requirements for outcome measures will require changes to the Department's MH, MR, and SA information technology services applications.
- Security management (HIPAA, Homeland Security) will require additional resources in the central office and state facilities.
- Federal requirements for an electronic health record are being considered. These requirements would impact technology needs in state facilities and CSBs.

To address these issues, the Department is establishing a structured information technology applications development environment. This environment will employ standard development and maintenance procedures and a standard set of development tools. Enhancements to data reporting and analysis processes to integrate data from multiple sources also will be made, such as data warehousing and data migration from obsolete platforms. Staff training and retraining will be a priority. This effort should result in more consistent applications that lend themselves to better integration and a more productive staff. It also will address some of the issues created by the VITA transition. Resources will be identified or obtained to support the security management process. This will free current resources to address issues related to supporting out-of-scope services.

The Department will continue to work with its CSB partners to develop a conceptual framework for behavioral health information interoperability across the services system and to design and develop a set of applications to address outcome measurement requirements for MH, MR, and SA services. Where possible, these applications will be integrated with the CCS application.

The Department IT Strategic Plan includes the following major IT projects:

- *State Facility Pharmacy and Community Services Pharmacy System:* This project is replacing an outdated stand-alone pharmacy system with one that can assist in adequately managing the accurate and safe dispensing of medications. This system, when implemented, will manage pharmacy functions, including prescription entry, medication dispensing, inventory control, reimbursement, and quality assurance. For the state facilities, the replacement system will be integrated with the Department's AVATAR system, which is used for individual admissions, discharges, and reimbursement functions.
- *Clinical Applications – Electronic Health Record (EHR):* This proposed project involves the purchase of a comprehensive clinical information system for behavioral healthcare that manages the care data of individuals receiving state facility services. In order to properly manage care provided, clinical data in the form of thousands of transactions per facility per day must be collected, stored, and analyzed using an EHR. This system would be implemented at all state facilities and in the central office. It would eliminate manual data processes that are still used in many clinical areas. An EHR supported by a suite of clinical applications will greatly reduce risk while increasing operational efficiencies, cost savings, and individual satisfaction

Goals, Objectives, and Action Steps

Goal 31: Assure that the capital infrastructure of state hospitals and training centers is safe, appropriate for the provision of current service methods, and efficient to operate.

Objectives:

1. Improve the capital infrastructure of state hospitals and training centers to assure their compliance with life safety and applicable building codes and their appropriateness for active treatment and habilitation services.

Action Steps:

a. Implement critical state facility repairs that are necessary to maintain certification or meet JACHO standards.

b. Develop new state facility designs that more appropriately and efficiently respond to the needs of individuals receiving services

c. Continue to update individual state facility master plans to respond to the programming needs of individuals.

Goal 32: Improve the ability of the Department, state facilities, and CSBs to manage information efficiently in an environment that is responsive to the needs of users and protects identifiable health information for individuals receiving public mental health, mental retardation, or substance abuse services.

Objectives:

1. Implement the Department's Information Technology Strategic Plan.

Action Steps:

a. Maintain a positive working relationship with the VITA-Northrop-Grumman partnership.

b. Follow VITA and COV standards necessary to assure a structured and secure information technology applications development environment.

c. Employ standard development and maintenance procedures and a standard set of development tools.

d. Work with the VITA-Northrop-Grumman partnership to implement COV infrastructure requirements related to current operating systems and software, interoperability, security, network and server performance, potential areas for consolidating or streamlining, and user satisfaction.

e. Implement a pharmacy information system for state facility pharmacies and the Community Resources Pharmacy.

f. Implement electronic health records in state facilities.

g. Implement a data warehouse that provides a common repository for storing integrated financial, clinical, and operational data across all state facilities and a decision support system offering "point and click" access to the data warehouse.

h. Ensure all Department websites and technology applications (developed and purchased) comply with the COV Information Technology Accessibility Standard (GOV 102-00).

i. Convert existing applications to platforms that allow more powerful and complex performance.

j. Invest in information technology staff training and retraining.

k. In collaboration with state facilities, CSBs, and other state agencies, design and develop a set of information technology applications to support transformation implementation activities and address outcome measurement requirements for mental health, mental retardation, and substance abuse services.

2. Meet federal expectations regarding the implementation of EHRs across the services system.

Action Steps:

a. Work with the CSBs and state facilities to promote the rapid development of a model EHR based on federal, state, and third party payor source demand.

b. Participate in a pilot program to connect EHR applications across clinical sites, including CSBs and a state facility in one region and evaluate its usefulness.

c. Develop and implement an EHR application, supported by a complete set of clinical applications, in all state facilities.

F. Human Resources Management and Development

Recruitment and Retention of Critical Positions

Several major human resources-related factors are expected to affect the quality, effectiveness, and responsiveness of services provided through Virginia's publicly funded services system and private providers. These include:

- The aging and increasing cultural diversity of the current workforce,
- Declining capacity to educate potential enrollments in key degree and specialty programs such as nursing;
- Declining enrollments in key degree and specialty academic programs such as nursing,
- The shortage of health care professionals and direct care workers,
- The increasing level of skills expected of the workforce in the future, and
- The declining overall size of Virginia's workforce.

These factors place pressure on public and private providers to increase the productivity of individual workers. Increased productivity can be accomplished by technology improvements, better matching of workforce skills with individual provider needs and individual acuity levels, and increased emphasis on education about new treatment modalities and professionally accepted clinical practices. A variety of education and compensation incentives will be needed to enhance skill levels and retain workers in key health care occupations, including expanded use of career ladders; on-site formal education for nurses, health care aides, case managers, and other licensed providers; and tuition reimbursement and grants for off-site educational programs. The community college system continues to assist in this educational effort.

As Virginia's population becomes more diverse, providers must increase the cultural competence of workforce members. In July 2001, the US Department of Health and Human Services Office of Minority Health released national standards on Culturally and Linguistically Appropriate Services (CLAS) in health care. These standards address culturally competent care, language access services, and organizational supports and include mandates (intended for recipients of Federal funds), guidelines, and recommendations. Services providers must identify the:

- Language needs of individuals receiving services who have limited English proficiency,
- Points of contact in the organization where language assistance is likely to be needed, and
- Availability of resources and ways to access them to provide timely language assistance.

In October 2007, the Department sponsored a Workforce and Cultural Competency Conference to promote services and improve access for multicultural consumers across Virginia. This conference educated service providers, policy-makers, and administrators about cultural competence and highlighted evidence-based practices and strategies for integrating cultural competence into ongoing service delivery and creating multicultural work environments.

The public mental health, mental retardation, and substance abuse services system faces a number of workforce development challenges that affect its ability to attract and retain nursing and direct care providers. Among these are intense competition among services providers and corresponding high turnover of staff to alternate employers, difficulty obtaining and retaining well-qualified nursing and direct service workers, limited opportunities for professional growth,

insufficient development training opportunities, and the influence of the system's negative public image on recruitment/retention of nursing and direct care personnel.

Across the services system, many public and private providers cannot attract and adequately compensate staff or provide training and development needed for career growth. This has limited the ability of providers to give needed levels of care and to assure health and safety. Current reimbursement rates for some services still do not cover service provision costs. Providers also experience extra costs associated with overtime, contract employees, and continuous recruitment and training due to excessive turnover. Some providers are being financially burdened to the point of reducing capacity or going out of business.

The continuing shortage of nurses has the potential to have significant service and financial impact on Virginia's publicly funded mental health, mental retardation, and substance abuse services system, including state facilities and community providers. The services system is having increasing difficulty attracting and retaining nurses, particularly in the area of mental health. Department workforce development initiatives to address these issues follow:

- Demonstration sites to encourage entry level and continued learning for nurses,
- Nursing career ladders or pathways,
- System-wide public awareness and education campaigns and conferences;
- Recognition programs, and
- Partnerships to seek funding resources to improve compensation.

Virginia's services system cannot meet current demand for direct care staff who provide essential hands-on care to individuals who must depend upon others for the most basic activities of daily living. Demand for these positions, such as state facility direct services associates, is growing more than twice as fast as all other industries. At the same time, service requirements and competencies have increased significantly. The inabilities of providers to attract, train, and retain qualified direct services support staff has been identified by all oversight entities. This problem affects state facilities, CSBs, and private programs, including Medicaid-funded services. Workforce development initiatives to address these issues follow:

- Continued learning programs utilizing long-distance learning techniques,
- Career ladders or pathways linked to educational awards, e.g., certificates, specialized diplomas, or associate degrees,
- Public awareness campaigns to educate and recognize direct care services and opportunities offered by the services system, and
- Partnerships to seek funding resources to improve compensation.

The Department, state facilities, CSBs, and private providers have established an ongoing partnership through the Workforce Advisory Council to jointly address continuing services system workforce issues, such as compensation, public image, access and availability of basic and continuing education for the nursing profession, lack of career ladders or pathways, availability of qualified candidates for key specialty roles in treatment settings, aging of the workforce, short tenure of the current workforce, increasingly physically and mentally demanding work environments, and market competitiveness for qualified candidates. The advisory council needs to continue to focus its efforts to strengthen the status of the direct support role and industry image; educate, train and develop frontline staff; develop career paths linked to education and training; secure systems change by improving income, linking wage enhancements to skill development; and revise public policy to provide the necessary tools for a transformation of the direct care worker to a direct care professional.

Implementation of High Performance Organization Principals and Practices

In March 2005, the Department initiated efforts to create a "high performance organization" within its central office and 16 state facilities. In collaboration with the University of Virginia's Weldon Cooper Center for Public Services and the Commonwealth Center for High Performance Organizations, the Department is moving towards an organization that values and expects shared leadership, teamwork, and collaboration. The High Performance Organization (HPO) process includes organizational assessment and change, relationship building, promotion of core competencies of leadership, and alignment between vision and values and structure and systems.

State facilities are working on high performance organization initiatives to enhance staff morale and general work conditions in each facility. Recruitment and retention issues continue to challenge the system as the workforce increasingly experiences the cycle of retirements and subsequent re-education of the new, replacement workforce. The Department has implemented an initiative to reduce mandatory overtime by July 1, 2007. However, until staffing levels are increased and recruitment and retention issues are more effectively addressed, the need for overtime will not be completely eliminated. Factors contributing to the use of overtime include, but are not limited to, elevated vacancy rates, requirements for one-on-one supervision, and employee absences due to sickness, disability, or Workers Compensation injury.

To date, a statewide Advancing Leadership and Organizational Team (A LOT) team, with representative from the state facilities and central office, has developed a Department leadership philosophy and is in the process of developing a plan of action for HPO. Central office and state facility employees have been trained in the HPO principles and change agents have been identified and are meeting throughout the system. The state facilities and the CO have started their unique plans of action to promote the HPO philosophy with much success. In 2007, the Department hired an Organizational Development Manager to partner with senior leaders, cross-functional teams and employees to coordinate and promote the large-scale organizational change through the HPO principles, methods and tools.

Training and Skill Development

Mental Health:

Preadmission Screening Evaluators Training – Virginia Code §37.2-808-809 specifies that designees or employees of local CSBs who complete evaluations to assess the need for psychiatric hospitalization, emergency custody, or involuntary temporary detention must complete a certification program approved by the Department. The Department in collaboration the VACSB Emergency Services Council and consumer and family representatives is reviewing, revising, and updating the certification process and will make recommendations regarding the minimum qualifications for preadmission screening evaluators and the core training curriculum. Approximately $47,500 annually has been allotted on an ongoing basis to support preadmission screening training.

Peer Specialist Training – After reviewing all curricular options, the Department has developed a request for proposals for Peer Specialist training programs, which was sent to known Peer Specialist training vendors on March 30, 2007 and posted on the Administrative Services procurement website. Three regional training events will have the potential to train 60-90 consumers from local communities, consumer-run programs, and CSBs over the coming year. It is anticipated that these trainings will begin in late summer of 2007.

The Recovery Education and Training Workgroup – This workgroup, one of several work teams created as part of the organizational structure to implement the System Transformation Initiative, is coordinating the planning for peer and provider recovery education and training. Workgroup membership includes Department staff, CSB and Regional Partnership staff,

consumers, and private providers. The workgroup has overseen the development and implementation of training plans to bring recovery-oriented practices to individuals who connect with crisis response services, crisis stabilization services, and inpatient services. These statewide trainings, funded with $165,000 in System Transformation funds, have reached more than 1,000 public and private service providers and consumers. The Recovery Education and Training Workgroup continues to play an active role in implementation of training for new Peer Specialists in Virginia and in articulating and advancing the vision for education and training for a recovery-oriented, consumer-driven system of care.

Mental Retardation:

Behavioral Support Training: Many direct care workers employed by MR Waiver providers, as well as many new providers, do not have experience or training in how to work with the work with the population served, particularly those with behavioral challenges resulting from co-occurring mental illness or autism. Best practice models of positive behavioral support are available, however training resources have been limited to Medicaid regulations for the past several years. On July 1, 2006, the Department implemented a system-wide, web-based training program, College of Direct Support (CDS), for staff serving people with disabilities to enhance the general training for direct care staff and providers. The CDS has proven to be a very promising on-line approach for increasing the competencies of direct care workers in both DMHMRSAS facility staff and private providers. The program allows individuals to earn college credit, thereby promoting an effective career ladder for otherwise difficult to retain staff. The Department has sponsored participation in this training in past years and will continue to do so through a $250,000 investment in FY 2008.

Substance Abuse:

Technological progress that has fueled advances in evidence-based practices also has produced an urgent need for a well-trained workforce. At the same time, the existing workforce is "aging out" and is not being replenished with younger workers. Technology transfer to the existing workforce and the attraction and retention of a younger workforce are critical issues in the field of treatment for substance use disorders. To address these issues, the Department has joined forces with the Mid Atlantic Addiction Technology Transfer Center (Mid-ATTC), one of 14 such centers in the nation supported by the federal Center for Substance Abuse Treatment, to bring science to practice by accelerating the time it takes for new scientific discoveries to be integrated into mainstream treatment for substance use disorders. Established in 1990, Mid-ATTC is a part of the Virginia Commonwealth University Medical School. The Department and Mid-ATTC are engaged in several initiatives, supported by a co-located staff position responsible for human resource development.

Virginia Institute for Professional Addiction Counselor Training (VIPACT) – Originally a joint venture with the State of Maryland in the 1980s, VIPACT is an established curriculum that trains entry level counselors to prepare them for the substance abuse certification examinations (CSAC and CSAC-A) offered by the Board of Counselors in the Department of Health Professions. The classes have been provided in a central location at no cost to CSB employees or employees of agencies providing contractual services to CSBs. Participants have included entry-level workers currently employed in community substance abuse treatment programs, nurses employed in state hospitals, and master's level mental health professionals seeking knowledge and skills to address the needs of individuals with co-occurring mental health and substance use disorders. VIPACT is currently undergoing revision to address the needs of professionals required to provide services to individuals with co-occurring disorders and to reduce staff travel and time commitments.

Virginia Summer Institute for Addiction Studies (VSIAS) - Every summer, the Department joins with a number of other state agencies and organizations, including the College of William and Mary, Mid-ATTC, the Virginia Association of Alcoholism and Drug Abuse Counselors, the

Virginia Association of Drug and Alcohol Programs, the Substance Abuse Certification Alliance of Virginia, the Substance Abuse and Addiction Recovery Alliance, the Department of Corrections, the Department of Criminal Justice Services, and the VACSB Substance Abuse Council to host a five day training event at the College of William and Mary. This training provides conferees with presentations and workshops delivered by nationally known experts in the treatment and prevention of substance use disorders. Topics range from basic knowledge to advanced training, including a three-credit graduate level course. Scholarships are provided to CSB prevention and treatment staff. The fifth annual weeklong event was held July 16-20, 2007 and was attended by approximately 1,000 professionals.

Co-Occurring Disorders – In 2004, the Department received a five-year $3.5 million grant from the federal Substance Abuse and Mental Health Services Administration to improve Virginia's ability to address the complex treatment needs of individuals with co-occurring mental health and substance use disorders. A component of this Virginia Service Integration Program (VASIP) supports ongoing training provided by Dr. Kenneth Minkoff and Dr. Christie Cline, leading experts in the field. VASIP activities began in early 2005 at 11 CSBs; in 2006 these activities were expanded to all 40 CSBs and the eight state hospitals that provide acute mental health care. In 2007 the Department will conduct a survey of mental health and substance abuse professionals in CSBs and state hospitals to identify where gaps in knowledge and skills exist. With data from the survey, the VASIP workgroup, along with the VASIP implementation team, will develop a training plan that will address identified gaps. The Department intends to develop a training plan to address identified gaps by mid-2008.

Statewide Training Plan – In collaboration with the COSIG/VASIP initiative, the Department is developing a comprehensive training plan to address the workforce development needs of individual professionals and systems. Based on recent breakthroughs in brain research and the continuing emphasis on evidence-based practices, the plan will be designed to meet the needs of the current workforce to develop and maintain awareness, knowledge, and skills to meet the demands of an increasingly complex set of consumer needs. It will also address systems needs for implementing transformation initiatives

Graduate Student Scholarship Pilot Program – In collaboration with the Consortium for Substance Addiction Organizations, the Department piloted a scholarship incentive program for the recruitment of master's level substance use disorder counselors in 2007. The scholarships are awarded to students who agree to pursue an addictions concentration in their graduate program, followed by a commitment to provide addiction services in the public sector for two years following graduation.

Prevention Training – Prevention has evolved into a science-based service and specific training in prevention theory and practice for CSB prevention management and staff is necessary for the implementation of effective prevention services in communities. Prevention training is provided through a specialized prevention track at the Virginia Summer Institute of Addiction Studies, the Prevention Comes First Conference. The Department also provides prevention-specific training and technical assistance to CSBs and conducts annual regional summits to update CSB prevention directors on changes and new developments in the field. Since 2004, 16 of the 40 CSB prevention directors are new and have minimal or no experience or training in prevention. To address this issue, the Department sponsors a formal mentorship program for new CSB prevention directors in which more experience prevention directors, through contract, provide monthly prevention practice supervision for one year to assigned novice directors. The Department also provided scholarships for CSB prevention directors to apply and test for the Certified Prevention Professional (CPP) certification exam provided by the Substance Abuse Certification Alliance of Virginia. Prevention textbooks and materials are distributed to all CSB prevention directors and staff, as available.

Goal 33: Partner with public and private organizations and providers to address systemic issues in recruiting and retaining an adequate workforce within the mental health, mental retardation, and substance abuse services system.

Objectives:

1. Provide opportunities for services system partners to actively participate in system-wide workforce initiatives and build partnerships for effective collaboration and consensus on workforce issues and initiatives and programs.

Action Steps:

a. Continue to partner with system stakeholders to address workforce issues and initiatives, including providing access to the College of Direct Support.

b. In collaboration with the Workforce Advisory Council, address system-wide workforce issues and prioritize initiatives for system-wide changes.

c. Share information and data with system stakeholders in order to address internal workforce issues and challenges.

d. Continue to plan and implement HPO initiatives in the central office and state facilities.

e. In collaboration with system-wide partners, include workforce initiatives in conferences and other educational forums.

2. Implement strategies to enhance recruitment and retention of critical positions.

Action Steps:

a. Partner with universities to obtain graduate students to assist in the development of a marketing and communications plan and a public education campaign for the recruitment and retention of critical positions.

b. Work with primary, secondary, and technical schools and institutions of higher education to educate their students about the services system and potential career opportunities.

c. Develop a system-wide recognition awards program for the mental health, mental retardation, and substance abuse services system's workforce.

d. Develop techniques to recruit and retain critical positions, including a toll-free call center, space advertisements, TV and radio public service announcements, an interactive web site, web promotion, brochures, posters, direct mail campaigns, employee referral cards, bumper stickers, newspaper articles and profiles, radio interviews, forums, exhibits, and outreach programs.

3. Implement a system of workforce planning for the Department in order to accurately project workforce needs and resources.

Action Steps:

a. Complete development of a comprehensive workforce plan that is linked to the Department's strategic plan and consistent with the requirements of the Virginia Department of Human Resource Management.

b. Use the workforce database to gather and analyze demographic workforce indicators for the plan.

c. Monitor the age and length of services of state facility key positions and conduct trend analyses regarding potential retirements.

d. Monitor the implementation of and update the comprehensive workforce plan.

Goal 34: Assure that the services system workforce is competent and well trained to provide quality services and supports.

Objectives:

1. Create partnerships with Virginia universities, colleges, community colleges, and other learning organizations to expand the numbers and competency levels of critical professional and direct care positions.

Action Steps:

a. Establish and support implementation of a developmental career path for state facility direct services associates.

b. Support scholarships and other incentives to increase the number of students entering training and academic programs for critical professional and direct care positions.

c. Assist current and future staff obtain scholarships and educational or financial aid.

d. Explore potential academic partnerships to support on-site-training of graduate, undergraduate, and medical students at state facilities and CSBs

e. Implement nursing and direct care professional distance-learning techniques on a statewide basis.

f. Continue to implement the College of Direct Support Program system-wide to enhance the efficiency and effectiveness of the state facility direct services associates training program.

g. Maintain and enhance the Department's Workforce Development and Innovation Web Site as a resource for services system partners.

h. Provide financial assistance to private providers to enable their participation in the College of Direct Support.

2. Increase the skills and productivity of professional, paraprofessional, and administrative support staff through distance learning, regional and statewide training programs, conferences, and other learning opportunities.

Action Steps:

a. Develop and implement on-site educational programs for direct services associates and nursing staff that support career ladder progression for future and current nursing professionals.

b. Develop and implement on-site educational programs that support career ladder and career paths for direct care professionals.

c. Evaluate and obtain continuing education programs for critical positions by partnering with the community college system to offer continuing education credits or certificates.

d. Implement training and cross-training programs designed to develop provider competencies necessary to meet the needs of the most challenging individuals, including individuals with co-occurring disorders and the gero-psychiatric population

e. Promote cross training of nursing home staff to address the needs of individuals who are at risk of institutional placement due to psychiatric or behavioral needs.

f. Explore the feasibility of establishing a certificate and associate degree program sequence for staff.

g. Evaluate and implement incentives such as certificates, pay differentials, and other methods of recognition for direct care workers who obtain in additional training.

h. Provide HPO leadership training to Department central office and state facility staff through a public academic partnership with the University of Virginia

i. Revise the MR Waiver Workbook to include information on positive approaches to supporting people with mental retardation and co-occurring MR/MI.

j. Develop more certified professionals in the area of behavioral consultation by combining workforce efforts with the Positive Behavioral Support project.

3. Enhance mental health service delivery among all providers of service, including CSB and state facility staff, peer specialists, consumers, and private providers.

Action Steps:

a. Provide ongoing training to CSB preadmission screening evaluators and continue to work with the VACSB, its Emergency Services Council, and consumers and family members to review, revise, and update, as appropriate, certification requirements for preadmission screening evaluators.

b. Provide regional Peer Specialist training to consumers from local communities, consumer-run programs, and CSBs to expand the cadre of providers of peer support.

c. Continue to plan for and implement recovery education and training.

4. Increase the basic knowledge and skill level about substance use and co-occurring disorders and evidence-based practices of current professionals and expose younger professionals to the field to these practices.

Action Steps:

a. Restructure and continue to implement the Virginia Institute for Professional Addiction Counselor Training, revising the curriculum as needed.

b. Continue to implement the Virginia Summer Institute for Addiction Studies and support participation by CSBs and their contract agencies.

c. As part of the VSIP initiative, conduct a training needs assessment of mental health and substance abuse professionals at the CSBs and state hospitals and develop a plan to address gaps in knowledge and skills in treating co-occurring mental health and substance abuse disorders.

d. With VSIP funds, provide scholarships to the Virginia Summer Institute for Addiction Studies to mental health professionals to improve their knowledge and skills in treating substance use disorders and co-occurring mental health and substance use disorders.

e. Continue to sponsor regional or onsite training offerings and seek other opportunities to enhance knowledge and skill in implementing evidence-based practices.

f. Continue to collaborate with the Mid-Atlantic Addiction Technology Transfer Center.

g. Continue to respond to developing trends and issues by sponsoring workshops and training events.

h. Continue to collaborate with other states and other state agencies to provide training.

5. Increase the number of training, support, and skill-building opportunities available to CSB prevention directors and staff on evidence-based prevention services that address prioritized risk factors and un-served populations.

Action Steps:

a. Expand the dissemination of prevention science and program information and materials by the Regional Alcohol and Drug Abuse Resource Center.

b. Provide orientation and mentoring for new prevention directors and staff in prevention science and the prevention database.

c. Continue to provide scholarships for experienced prevention directors applying for prevention certification.

d. Provide training and technical assistance to CSB staff and other prevention professionals in community-based prevention planning, collaboration, and universal and selective evidence-based prevention programs, program development, and evaluation through the Virginia Summer Institute for Addiction Studies.

e. Continue the development and expansion of technology capacity through training and technical support to CSBs in the use of the prevention data system.

G. Service Quality and Accountability

Oversight and Accountability Activities and Challenges

As Virginia's system of public mental health, mental retardation, and substance abuse services is transformed, the Department must take affirmative steps to create a culture of recovery, self-determination, and person centered planning. The Department also must assure that individuals being served receive quality services that are effective and appropriate for their specific needs. To achieve this, the Department emphasizes a variety of quality improvement and oversight activities, including licensing services providers; protecting the human rights of individuals receiving services in state facilities and community programs; implementing a "zero tolerance" abuse and neglect policy in state facilities; reducing the use of seclusion and restraints, evaluating treatment through peer review; and monitoring the quality, performance, and utilization of community and state facility services.

Licensing Services Providers: By Code, the Department is required to license providers that offer services to individuals with mental illness, mental retardation or substance use disorders, developmental disability waiver services, and residential brain injury services. The Department licenses all new services, renews licenses, conducts annual unannounced inspections, investigates all complaints in licensed services, reviews reports of serious injuries and deaths, and initiates negative action, including sanctions and revocations, against providers. The Department enforces regulations that promote the health and safety of individuals receiving the services and the surrounding community. These regulations include provider responsibilities for preparing for and responding to emergencies and disasters. The Department ensures that applicants who become licensed meet and maintain adherence to these regulatory standards of health, safety, service provision, and individual rights.

The current caseloads of the Department's licensing specialists are significantly higher than are the licensing caseloads of other agencies. Department licensing caseloads have grown each year as the number of providers of mental health, mental retardation, and substance abuse services has increased and new statutory requirements have been enacted to license providers of developmental disability waiver and brain injury services. In FY 2007, the number of licensed providers increased by approximately 18 percent. This increase was due to the expansion of community services and funding. A JLARC study in 1996 has recommended that the Secretary of Health and Human Services study licensing caseloads among the child-serving agencies to develop uniform standards. While the General Assembly appropriated funding in 2006 for three additional licensing positions, those positions were not filled due to a loss of federal funding. Funding for two of these positions has been restored by the 2007 General Assembly. Additional licensing specialist positions are still needed to manage current caseloads and address projected future growth in caseloads and increased oversight requirements.

The Department is revising the Department's licensing regulations to incorporate the concepts of recovery, empowerment, and self-determination, reduce administrative burdens, where possible, and promote health and safety. The Department convened diverse groups of individuals to review the current regulations and recommend changes. The Department plans to have a new set of regulations available for public comment in early FY 2008.

In conjunction with the Coordinating Committee for Interdepartmental Regulation of Children's Residential Facilities, the Department is also in the process of revising the children's residential facility regulations that should become effective by the end of December 2007. It is anticipated that implementation of these new, more rigorous regulations will result in increased negative action against providers, thereby adding to the already strained ability to keep pace with a burgeoning licensing caseload.

Protecting Individual Human Rights: The *Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers of Mental Health, Mental Retardation and Substance Abuse Services* (12 VAC 35-115-10 et seq.) explain and expand upon the fundamental rights of individuals receiving mental health, mental retardation, and substance abuse services described in § 37.2-400 of the *Code of Virginia*. The regulations recognize that individuals receiving services have a right to full participation in decision-making and to receive treatment in accordance with sound therapeutic practice. They define the composition, role, and functions of the Department's human rights system, including Local Human Rights Committees (LHRCs) and the State Human Rights Committee (SHRC). The regulations also establish time frames and clear procedures for resolving individual complaints.

In 2004, the Department began an extensive process of revising the regulations in accordance with the Virginia Administrative Process Act. During this process, over 88 individuals and groups submitted comments on the proposed revisions to the regulations. The Department and members of the State Board carefully considered every comment. The Executive Branch approved the regulations for final adoption in July 2007. The Department intends to offer training on the new regulations to consumers, families, local and state human rights committee members, providers, and other interested parties.

The Department makes advocacy services available to approximately 190,000 individuals receiving services from state facilities, all services licensed by the Department, and all services funded by the Department. The agency assisted with or monitored the investigations of 3,533 allegations of abuse and neglect and 1,197 human rights complaints in 2006. The Department also monitors all providers for compliance with 12 VAC 35-115, et seq., and provides consultation, training, and assistance to over 420 volunteer members of the 68 LHRCs.

A study completed in response to Item 323 of the FY 2000 Appropriation Act concluded the Department's human rights advocacy system operations far exceeded its capacity. This situation has not improved. With the increasing emphasis on community-based care and the corresponding expansion in the number of licensed providers and services, new demands have been placed on the Department to assure that the rights of individuals are protected. Human rights advocates will continue to experience increasing demands for consultation to and monitoring of human rights protections in new services. Because the current LHRCs are beyond capacity across the state, the continuing growth in the number of licensed providers has resulted in the need to recruit, develop, and train new local human rights committees. Investigations of allegations of abuse and neglect and human rights complaints all have increased significantly due to growth in the numbers of new providers and services.

Investigating State Facility Abuse and Neglect Allegations: The Department has established a "zero tolerance" policy with regard to abuse and neglect allegations in state facilities. To implement this policy, the Department established an Abuse/Neglect Investigations Unit in 2000. Working closely with Department human rights and human resources staff, the unit works to ensure that state facilities protect individual safety and adhere to Human Rights Regulations requirements related to abuse and neglect. The unit has trained and certified around 70 investigators throughout the state facility system and has processed approximately 3,700 allegations since its inception.

Reducing Use of Seclusion and Behavioral Restraint*:* The provision of non-coercive treatment and care in the state hospitals, including the reduction and elimination in the use of seclusion, restraint, and time-out, continues to be a priority of the Department and a focal point for the Office of the Inspector General. Therapeutic Options of Virginia (TOVA) is the Department's standard behavior interaction-training program that was developed to meet the specific needs of facility staff that work with individuals with mental illnesses or mental retardation. An Advisory Committee, which includes consumer and CSB representatives, provides oversight for the structure, content, and operations of the TOVA program and ensures that the program is updated to meet the changing needs of consumers and staff. The

Department's seclusion and restraint database has now been in operation for more than two years and serves as the basis for internal and external reporting of these restrictive procedures. In addition to this internal database, the Department annually collects data on the use of seclusion and restraints from all licensed providers of mental health, mental retardation and substance abuse services. Policies, procedures, and regulations are in place and are continuously updated to support reduction efforts.

Evaluating Treatment and Services: Peer review is a privilege afforded physicians under the *Health Care Quality Improvement Act of 1986* and by state laws governing peer review activities. It is critical that such a privilege be guided by a set of clear rules and requirements. To this end, the Department has developed policies and procedures to formalize its quality management processes, to protect the confidentiality of individuals receiving state facility services, to insure the appropriate use of peer review information, and to distinguish this review from other administrative and operational review mechanisms. Additionally, the Department's Clinical Services Quality Management Committee (CSQMC) reviews, evaluates, and makes recommendations regarding resident and patient safety, the duration of patient stays in facilities, the adequacy and quality of professional services rendered, the efficiency and use of facilities and services provided, and the competency criteria and qualifications for granting professional staff privileges. The CSQMC Clinical Case Review Subcommittee reviews the quality of care provided in specific clinical cases, reviewing clinical issues with system-wide importance, and reviewing and responding to the OIG's Secondary Inspection Reports relative to clinical matters. CSQMC and the Clinical Care Review Subcommittee reviews are important tools that allow the Department's leadership to continuously evaluate and improve quality of care.

The Department has, for many years, submitted data to the NASMHPD Research Institute for state facilities that are accredited under Joint Commission on Accreditation of Health Care Organizations (JCAHO) Hospital Accreditation Standards. During the last biennium, the Department began to automate the data collection process and most data is now extracted from existing databases and transferred into the ORYX database and reporting system. The ORYX database will provide the Department with a quality management data warehouse that can be used to evaluate risk, quality, and outcomes at the individual or state facility level. When completed, this warehouse will allow staff to access data for operational research and reporting to the Department's CSQMC and other internal and external quality and risk-related reporting requirements.

In the summer of 2005, the *Patient Safety and Quality Improvement Act* was signed by the President to promote cultures of safety across health care settings. This act establishes federal protections that encourage thorough, candid examinations of the causes of health care errors and the development of effective solutions to prevent their recurrence. The legislation grew out of claims by the Institute for Medicine and JACHO that existing health care practices drove errors underground because caregivers did not feel safe to report errors and, therefore, could not collectively learn from their mistakes. The Department has initiated a "Just Culture" program that embraces state facilities as learning environments and state facility staff as teachers and promoters of patient safety and quality improvement. Through this program, the Department is implementing the Risk Management and Patient Safety Institute's critical steps, which include: acceptance that a blaming approach will not prevent error, open discussion about errors and near misses, system-wide allowance for mistakes to occur, acceptance of the possibility of failure, and acknowledgement that errors may be expected and the workforce must be trained to identify and recover from errors.

Improving Quality Through Electronic Health Records (EHR): It has been well documented that implementation of an EHR can provide significant improvements in consumer safety and clinical outcomes. However, increased clinical effectiveness is possible only when selection, design, and implementation are guided by the needs of the staff who provide direct care services. Clinical work processes must be reviewed and revised as necessary to take

advantage of this new technology and information systems must support and enhance the work of clinicians through decision support systems, improved access to information, and a system of warnings and alerts. This requires the active participation of clinical and other direct care staff in developing the specifications, selection, training, migration planning, and on-site implementation of a system. The Department has established an e-Records Team t o provide policy-making, oversight body to guide the project. Ten EHR Teams are meeting regularly to plan for implementation of an EHR. The teams include senior level clinicians from all disciplines, administrators, and a variety of direct care and support staff to serve as the subject matter experts in planning for this new system. In addition, an effort is underway to replace the existing pharmacy system.

Managing Potential Risks and Liabilities in State Facilities: Department and state facility leadership and staff must proactively address risks and liabilities inherent in ongoing programs and daily operations. Management of risks and liabilities continues to take on new dimensions, including implementation of federal regulations governing the privacy and security of patient identifiable information under the *Health Insurance Portability and Accountability Act of 1996* (HIPAA), which took effect in April 2003. In addition, §51.5-37.1 of the *Code of Virginia* requires the Department to report all deaths and critical incidents to the Virginia Office for Protection and Advocacy (VOPA) within 48 hours of occurrence or discovery and provide follow-up reports of the known facts. A VOPA Incident Tracking System database in the central office assures implementation, monitoring, and documentation of compliance with this requirement.

Managing Service Utilization: Utilization management (UM) uses established, industry-accepted standardized processes to conduct a review of the need (utilization review) and the best use of available mental health resources (utilization management) before, during, and after a period of service such as an episode of care. Implementation of a comprehensive and consistent UM system would require integration of data from multiple sources and multiple providers and would need to be automated at a system-wide level. The variety of service settings and multiple service programs compound the difficulty in aggregating and analyzing service use patterns. Implementing a UM infrastructure at the system level would focus on:

- Establishing clinical criteria compatible with the specific service level, initially in inpatient psychiatric and crisis stabilization services
- Collecting these data and clinical profile data in a consistent manner
- Communicating these data to the interested services providers, such as regional partnership planning groups, CSBs, state hospitals, and purchase of services contractors;
- Collecting data in clinical profiles for use in describing the characteristics of special needs populations such as individuals with co-occurring mental illnesses and substance use disorders.
- Benchmarking these data with other state and federal datasets; and
- Evaluating the efficiency and effectiveness of the public system to provide services using the characteristics of access, quality, and cost.

The Department and CSBs would need additional resources to establish the data system required to capture and report these data. However, data available through a comprehensive UM system could be used and managed by the state hospitals, CSBs, and Regional Planning Partnerships. Potential outcomes could include improved care and reduced cost by data-derived matching of severity of illness to treatment level. Data could also be used to inform clinical and administrative best practices.

While implementing this system would be a long-term project that would occur over several biennia, the Department and CSBs have already initiated several efforts in this area. Every regional planning partnership has implemented a memorandum of agreement for its local inpatient purchase of services funds that includes utilization management processes; however,

variations exist among these processes from region to region. Also, the System Leadership Council adopted a Regional Utilization Management Guidance document on January 10, 2007 to strengthen these utilization management processes. The Department and CSBs are now implementing this guidance.

Medications Tracking: Pharmaceuticals represent an ever-increasing percentage of health care budgets in Virginia. Knowledge and understanding of individual practitioner and system wide prescribing activity is essential for cost effective and high quality delivery of mental health medications. In order to promote optimal medication management practices, the Department's pharmaceutical prescribing data are reviewed at both the facility and community services level. Additionally, clinical and educational data, e.g., mood charts, sleep charts, and patient medication information sheets, are now available to CSBs and facilities through a newly created information web-based "portal" and reporting tool.

Through the development of the Medis (Medication Information Systems) data warehouse, data are extracted, assembled, and reviewed at state facility pharmacies and the Community Resource Pharmacy, allowing for a careful and thorough review of individual practitioner prescribing patterns. Considerable knowledge has been gained about the systems medication use practices as a result of this activity, as well as through the ongoing work of the State Pharmacy and Therapeutics Committee. Prescribing data can be matched with indicators of clinical progress to determine the impact and efficacy of specific medications. Additionally, the Medis system, in coordination with the newly created web portal, has allowed the Department's pharmacies to track medication costs and use to manage medication expenditures more efficiently and effectively.

Transformation Initiative Data and Outcomes Measures

The Data/Outcomes Measures Workgroup was established in January 2006 to coordinate the development of outcomes measures for the Services System Transformation Initiative. Workgroup membership included mental health, child and adolescent, mental retardation, and substance abuse services representatives. Representatives included individuals receiving services; advocates; a private provider; the director of a university-affiliated treatment center for children; a CSB executive director; CSB and state facility quality assurance directors; a CSB planning and information systems director; and staff from two state agencies. The workgroup decided that its recommendations should emphasize systems outcomes that are largely related to the transformation process rather than consumer-specific outcomes, a number of which (e.g., employment status and education status, housing stability, abstinence, social connectedness, perception of care, and criminal justice involvement) have already been identified in the SAMHSA National Outcomes Measures (NOMs) and are required by the federal substance abuse and mental health block grants.

To measure services system transformation, the workgroup expressed support for both:

- A process to be used by organizations such as CSBs, state facilities, private providers, and the Department's central office to support dialogue among consumers, family members, and providers (e.g., focus groups); and
- A uniform instrument or survey, targeted to a specific population group, to be used to measure consumer, family, and provider perspectives and to gauge shared values.

The Data/Outcomes Measures Workgroup stressed the importance of focusing on a minimum number of outcome measures and data elements that are useful, realistically available, minimally burdensome or costly to collect, and easy to understand. This orientation has been endorsed by the Executive Directors (ED) Forum of the VACSB, which has prioritized its commitment to collection and reporting of data that is meaningful to the Boards themselves and to the communities they serve. The ED Forum has recognized that data collection and reporting must be tempered by an appreciation of the added administrative burden and costs associated

with new or expanded data requirements. The Data/Outcomes Measures Workgroup supported this orientation and recommended that the Department start with a small number of simple measures and build on experience with them. The workgroup recommended the following measures to the Department for short-term implementation.

Recovery, Resilience, Empowerment, and Self-Determination:

- Number of CSBs that use the Recovery-Oriented Systems Indicators (ROSI) as a quality improvement mechanism

Services System Transformation:

- Number of CSBs and state facilities that have a mechanism for transformation dialogue and action and an objective mechanism for tracking transformation
- Number of CSBs and state hospitals that have formally adopted the Comprehensive, Continuous, Integrated System of Care (CCISC) principles of service integration for individuals with co-occurring psychiatric and substance use disorders and are engaged in a continuous quality improvement process to implement these principles
- Number of consumers who are paid as peer providers
- Number of individuals receiving consumer wellness planning or leadership training
- Number of consumers and family members on CSB boards, the State Board, and State and Local Human Rights Committees
- Percent of children and adolescents with serious emotional disturbance, adults with serious mental illness, individuals with mental retardation, and adolescents and adults with substance use disorders (prevalence) who receive CSB services (calculated separately for each population group)
- Number of children, adolescents, and adults per 10,000 population who receive CSB mental health, mental retardation, or substance abuse services (calculated separately for each population group).

Transformation Initiative Implementation:

Potential measures, tied to the System Transformation Initiative language in item 312 of the 2006 Appropriation Act language, follow.

- Numbers of additional consumers served through Services System Transformation Initiative services, including MR waiver slots, community MH discharge assistance funds, MH community-based recovery services, crisis stabilization services, and community-based services for individuals who otherwise would be served by the replaced state hospitals or training centers
- Increases in community capacity (e.g., slots, beds) as a result of transformation initiative services
- Increases in the numbers of infants and toddlers served in Part C programs
- Numbers of children and adolescents served through new System of Care Demonstration Projects
- Numbers of juvenile detention center residents served through expanded MH services
- Compliance with key state facility replacement milestones:
  - Reduction in census of replacement facilities and patient/resident movements
  - Changes in staffing at replacement facilities and staff movements
  - Progress in construction of replacement facilities.

These measures represent an initial phase of a longer-term process of defining measures for services system transformation. They are intended to focus on how many CSBs are actually involved in system change and on consumers' perceptions of how this change is being

operationalized. The workgroup's intent was to implement these measures on a pilot basis before their inclusion in as Performance Contract requirements. Finally, the workgroup encouraged the Department to establish a process and assign specific staff responsibility within the central office for monitoring implementation of these measures, providing assistance and support to CSBs, coordinating the development of specific services system transformation measures for child and adolescent, mental retardation, and substance abuse services.

Goals, Objectives, and Action Steps

Goal 35: Enhance the Department's oversight of quality of care and protection of individuals receiving mental health, mental retardation, substance abuse, developmental disabilities, or brain injury services.

Objectives:

1. Increase the number of licensing inspections in residential settings.

Action Steps:

a. Monitor the frequency of residential inspections.
b. Review all licenses within six months of expiration.
c. Identify work assignment strategies to ensure residential inspections are made and licenses are issued in response to workload demands, vacancies, and emergencies.
d. Establish a centralized call center for human rights and licensing complaints.
e. Seek funds to hire additional licensing staff.
f. Address the level of violence in adolescent residential treatment facilities by convening a work group comprised of adolescent residential treatment providers to identify strategies to serve children who are aggressive.

2. Revise the existing licensing regulations to assure consistency with the Department's mission and goals.

Action Steps:

a. Develop revised regulations for licensing providers that offer services to individuals with mental illness, mental retardation or substance use disorders, developmental disability waiver services, and residential brain injury services during early FY 2008.
b. Implement the revised licensing regulations during FY 2009.

3. Implement the new interdepartmental Children's Residential Facility Regulations to improve the quality of care in these facilities.

Action Steps:

a. Facilitate the process for revising the interdepartmental regulations for children's residential facilities by December 2007.
b. Train staff and providers on the new regulations in early calendar year 2008.

4. Promote access to community services through approval of qualified providers in a timely manner.

Action Steps:

a. Implement the recently reorganized applicant approval process during FY 2008.
b. Continue to make improvements to applicant training.

Goal 36: Implement a high quality, effective, efficient, and responsive human rights system that protect the rights of each individual receiving services from providers of mental health, mental retardation, or substance abuse services.

Objectives:

1. Increase the effectiveness and efficiency of the human rights system.

Action Steps:

a. Train all partners on the revised human rights regulations.

b. Provide guidance and technical assistance on new regulations aimed at promoting treatment in the most integrated settings and enhancing consumer decision-making.

c. Develop a data system that links community and state facility data to the licensing database.

2. Increase the availability of human rights advocates to individuals in accordance with the recommendations in House Document No. 21 (2001); "Evaluating the Human Rights Advocates in State Facilities and Community Programs."

Action Steps:

a. Seek funding to increase the number of human rights advocates.

3. Ensure that individuals who lack capacity to provide informed consent have uninterrupted access to appropriate treatment and services.

Action Steps:

a. Increase the number of guardians and other substitute decision-makers for individuals receiving services in state facilities and community programs.

b. In collaboration with services system partners, pursue specific options for increasing the availability and training of individuals to serve as surrogate decision-makers.

Goal 37: Promote the use of non-coercive techniques and reduce the use of seclusion and behavioral restraint in state facilities and community services.

Objectives:

1. Promote the concept of training and treatment without coercion in state facilities and community services.

Action Steps:

a. Work with state facilities and private psychiatric hospitals to reduce practices of seclusion, restraint, and forced medication.

b. Identify needs for training, consultation, and advocacy regarding the use of seclusion and restraint.

c. Provide ongoing training and consultation for state facility and community providers focused on building the skills necessary to implement the vision of a system that supports recovery in a non-coercive environment.

d. Evaluate the ongoing effectiveness of the TOVA program and optional components to the program.

e. Develop strategies to make TOVA more accessible to community programs.

2. Continuously evaluate the utilization of restrictive procedures in state facilities and their effects on the health and safety of consumers and staff.

Action Steps:

a. Routinely review seclusion and restraint data and evaluate the effectiveness of reduction strategies, training programs, and other activities designed to reduce the use of restrictive procedures.

b. Convene a Seclusion and Restraint Advisory Committee to oversee and guide agency efforts to reduce seclusion and restraint.

c. Conduct in-depth analysis of the seclusion and restraint data of facilities that have not demonstrated significant decreases in their use of these techniques.

d. Evaluate community seclusion and restraint data to identify trends and training needs and to assess data reliability.

Goal 38: Ensure that Department and state facility quality management review functions are implemented according to clearly articulated policies and procedures.

Objectives:

1. Implement structures and processes to protect privileged case referral, information review activities, data collection, external consultation, record keeping, and reporting.

Action Steps:

a. Continue to safeguard and maintain the confidentiality of individual information and quality management review activities that are generated by the CSQMC.

b. At least annually, provide for an independent review of the safeguards in place to protect individual information and the privileges granted to the CSQMC by the *Health Care Quality Improvement Act of 1986.*

2. Evaluate the effectiveness of clinical guidelines and operational procedures as tools for improving the quality of state facility treatment, care, and clinical services.

Action Steps:

a. Provide the CSQMC with continuous feedback about the effectiveness of treatment, care, and clinical service requirements.

b. Provide data about important aspects of care, serious events, and other information that reflect the process and outcomes of treatment, care, and clinical services to the CSQMC.

c. Through the CSQMC, routinely evaluate the effectiveness of clinical guidelines to determine the need for revisions and identify problems in service delivery that may require new uniform clinical guidelines.

3. Periodically evaluate the functions, activities, and effectiveness of the CSQMC, as they relate to clinical case review, leadership, and oversight of important aspects of quality care.

Action Steps:

a. Implement an independent review process to evaluate the effectiveness of the CSQMC.

b. Submit a written report of the results and recommendations for improvement to the Commissioner and the members of the CSQMC.

Goal 39: Assure that publicly funded services provided in state facilities and CSBs are based on sound research that assures the highest quality treatment and the best clinical outcomes for individuals.

Objectives:

1. Expand the capability of the Department to conduct research.

Action Steps:

a. Identify the critical issues related to services quality for potential research and develop a research agenda based on these issues.

b. Use the Seclusion and Restraint Database to conduct research on effective strategies to manage volatile behavior among individuals in state facilities.

c. Continue to develop the quality management data warehouse as a research tool for evaluating risk, quality, and outcomes.

Goal 40: Achieve a learning environment that promotes quality care and safety of individuals receiving services in state facilities.

Objectives:

1. Develop a state facility infrastructure to encourage a learning environment of reporting, reviewing, and learning from errors.

Action Steps:

a. Establish criteria for learning environment case review pathways.
b. Promote the concept of a learning environment with the State Human Rights Committee, VOPA, OIG, state facility directors, advocates, and central office staff.
c. Develop and implement training on the use learning environment case review pathways in individual facility case reviews.
d. Measure effectiveness of the improvements in reduction of error rates.

Goal 41: Implement a comprehensive and consistent system-wide approach to public mental health utilization management.

Objectives:

1. Develop a utilization management infrastructure for state hospitals and CSBs.

Action Steps:

a. Implement the Regional Utilization Management Guidance.
b. Using the results of the Regional Utilization Management Guidance implementation, establish clinical criteria for specific levels of service utilization, initially for inpatient psychiatric and crisis stabilization services.
c. Develop a proposal and cost–benefit analysis for an automated database that integrates multiple data sources and multiple providers.
d. Generate support for the collection of utilization management data among providers through training, education, and the dissemination of relevant literature.

Goal 42: Improve the medication practices of physicians, pharmacists, and nurses who have a role in the medication management process in community and state facility services.

Objectives:

1. Continue to develop and expand the capabilities of the MedIs system in state facility pharmacies and the Community Resource Pharmacy.

Action Steps:

a. Develop and expand the reporting and evaluation capabilities of MedIs to include medication usage, medication history, and clinical outcomes for individuals at admission and discharge in order to enhance cost effective and efficient prescribing decisions to improve consumers' quality of life and clinical outcomes.
b. Continue to use Medis reports to assess prescribing practices of individual practitioners, treatment team decision-making, quality oversight processes, and medication costs.
c. Implement an inventory monitoring process that reduces excess inventories while ensuring the availability of normal stock levels for medications.

d. Provide sufficient numbers of trained pharmacy staff to ensure service quality and patient safety in all aspects of medication management and administration.

Goal 43: Document the successful implementation of the Transformation Initiative.

Objectives:

1. Establish Transformation Initiative outcomes measures and data reporting requirements.

Action Steps:

a. Review and take action on the recommendations of the Data/Outcomes Measures Workgroup.

b. Assign central office staff responsibility for coordinating implementation of selected outcomes measures, arranging for support and assistance to CSBs, and monitoring implementation of selected measures.

c. Develop, in collaboration with system stakeholders, specific services system transformation measures for child and adolescent, mental retardation, and substance abuse services.

2. Collect and report data on selected Transformation Initiative outcomes measures.

Action Steps:

a. Work with the VACSB Data Management Committee to establish a process for data collection and reporting of selected outcomes measures.

b. Establish a process for pilot testing selected outcomes measures.

c. Monitor, in collaboration with the VACSB Data Management Committee, pilot test results.

d. Determine, based on the pilot results, which outcomes measures should be included as Performance Contract requirements.

VI. RESOURCE REQUIREMENTS

The Department, in concert with various commissions, panels, studies, and investigations, has identified the following resource requirements to respond to critical issues facing Virginia's behavioral health and intellectual disabilities services system. This listing of resource requirements is far more extensive than has been identified in the past years due to the numerous commissions, panels and studies that have published funding recommendations in the last year. However, given the current budget constraints facing the Commonwealth, the Department recognizes that addressing these recommendations will require a multi-biennia investment of resources.

Post VA Tech Service Access and Accountability Initiatives: Investigations following the Virginia Tech critical incident by the Virginia Tech Review Panel and the Office of the Inspector General (OIG) revealed major gaps in service capacity across the Commonwealth, particularly in the areas of emergency and crisis stabilization services, outpatient services, and case management. Additional findings focused on the need to improve the consistency and accountability of these services and to reduce stigma associated with mental illness.

Targeted Emergency and Crisis Stabilization and Intervention Services: Post VA Tech investigations documented extensive delays in securing a willing detention facility during the commitment process. Recently, the General Assembly provided support for 12 crisis stabilization programs. To address the statewide need for emergency and crisis stabilization services, including additional secure crisis stabilization beds that accept temporary detention orders and other emergency and crisis stabilization alternatives, the Department estimates that $17,000,000 (annualized) would be needed.

Mental Health Outpatient Services: Outpatient treatment options need to be expanded to enable CSBs to adequately and appropriately respond to involuntary court ordered referrals and voluntary referrals for these services. These options include therapeutic support and interventions for individuals who are struggling with emerging mental health problems, follow-up clinical support for individuals who have recently experienced a mental health crisis, and treatment for individuals who have been ordered to outpatient treatment as a result of a commitment heating. Current CSB capacity to provide outpatient services is extremely limited. Statewide, there are 1.64 FTEs serving adults and 1.18 FTEs serving children and adolescents in CSBs per 50,000 population. For half of the CSBs, this capacity has declined during the past decade. Increased services system outpatient capacity would require $17,094,083 (annualized) to achieve a staffing ratio of 3.25 adult services clinicians per 50,000 population (244 positions); $16,653,555 (annualized) to achieve a ratio of 2.75 children's services clinicians (per 50,000 population 238 positions); and $17,019,734 (annualized) to achieve a ratio of 1.2 psychiatrists per 50,000 population (76 positions).

Case Management Services: Additional CSB case managers are needed to enable the CSBs to provide more adequate supports to individuals with serious mental illnesses and those who receive treatment services involuntarily and to assure that court-ordered treatment can be monitored more closely. Adding 230 case managers, at an annualized cost of $11,500,000, would achieve a caseload closer to the 25 persons per staff member recommended in national studies.

New River Valley Response Services: Previous incidents of mass violence in Virginia have demonstrated that when individuals and communities experience multiple tragedies in a short period of time, crisis counseling services have proven effective in promoting individual recovery and building both individual and community resilience. An important lesson learned from these tragedies is that the behavioral health response to mass trauma needs to fully address the emotional, physical, cognitive and behavioral reactions in order to mitigate the psychological impacts of acts and threats of violence. These services

include individual and group psycho education, individual and group crisis counseling, referral services, community outreach, crisis mental health services and peer training/stress management for first responders. The Department estimates the $750,000 would be needed each year for a two year period to assure that these crisis counseling services are available to individuals residing in the New River Valley community.

Anti-Stigma Campaign: The April 16, 2007 tragedy at VA Tech and ensuing media coverage reinforced negative stereotypes the public may hold about people with mental illnesses. Stigma affects how current consumers are treated and adversely affects the willingness of individuals to come forward for necessary treatment. Approximately $150,000 (annualized) would be needed to develop and implement a stigma reduction campaign focused on audiences that are in frequent contact with the mental health system, including schools, neighborhood and community associations, key policy-makers, law enforcement, the faith community, employers, and to an extent, in the general public.

Child and Adolescent Services: The report of the Child and Family Behavioral Health Policy and Planning Committee, established to meet the requirements of Budget item 311-E, includes the following priority recommendations to address the needs of children and their families:

(a) $40,000,000 (annualized) would be needed develop intermediate-level community-based services, including day treatment, intensive case management, and crisis stabilization, and other intermediate community-based treatment services designed to keep children and adolescents out of high-cost residential services in all CSBs;

(b) $3,600,000 (annualized) would be needed to expand by 12 the number of Systems of Care projects;

(c) $2,500,000 (annualized) would be needed to provide, in each CSB, MR family support services, including financial assistance, services, and technical supports identified by families to maintain their eligible family member at home;

(d) $6,000,000 (annualized) would be needed to fund MR waiver slots for children;

(e) $3,746,000 (annualized) would be needed to fund Part C early intervention services;

(f) $375,000 (annualized) would be needed to fund an additional three Project LINK sites to provide intensive case management to substance-using pregnant, parenting, and “at-risk” women and their children;

(g) $3,000,000 (annualized) would be needed to fund substance abuse services for pregnant and parenting women with substance use disorders who have complex, multifaceted treatment needs that few treatment programs can accommodate;

(h) $1,800,000 (annualized) would be needed to fund school-based mental health services in 20 middle schools in five regions;

(i) $990,000 (annualized) would be needed to fund infrastructure in the Department’s Office of Child and Family Services to support efforts to increase service system capacity statewide;

(j) $1,036,000 (annualized) would be needed to add four new child psychiatry fellowship slots and two new child psychology internship slots at state universities and academic medical centers for individuals who are willing to work in underserved areas in Virginia;

(k) $700,000 (annualized) would be needed to establish three Centers of Teaching Excellence to organize, coordinate, and lead clinician training in evidence-based, promising, and best practices for serving children with behavioral health treatment needs;

(l) $100,000 (annualized) would be needed to support a statewide family information network that links families in need with available services and provides peer support from others with similar experiences.

Geriatric Services: Virginia is experiencing a dramatic increase in the number of citizens who are over the age of 65. The Department has initiated pilot projects in two regions that are

designed to develop community-based services and supports to divert and discharge older adults from state geriatric psychiatric facilities. To expand regional projects to the remaining regions would require $5,000,000 (annualized).

MR Services System Study Recommendations: The 2006 General Assembly directed the DMAS, in collaboration with the Department, the Virginia Association of Community Services Boards (VACSB), the Arc of Virginia, and other stakeholders, to review the current Medicaid MR waiver to determine how the waiver could be improved. The 2007 General Assembly expanded this study to include the entire system of intellectual disability services delivery in Virginia. The study identified gaps and barriers and identified resource requirements totaling $264,925,606 in state general funds and $164,723,213 in non-general funds in FY 2009 and $264,925,606 in state general funds and $164,723,213 in non-general funds in FY 2010. Resource requirements, excluding those impacting waivers other than the MR waiver, follow:

(a) $27,680,000 in state general funds and $27,680,000 in non-general funds would be needed to fund MR waiver slots for 800 individuals per year, $3,200,000 would be needed each year to provide residential and day support start-up funds, and $48,000 in state general funds and $48,000 in non-general funds would be needed to purchase and implement a statewide assessment tool;

(b) $13,000,000 annually would be needed for new construction in the community of small residential models (4 beds or fewer) and needed renovations to training centers;

(c) $40,000,000 would be needed each year to provide supports for individuals with intellectual disabilities who have no other avenue for receiving supports;

(d) $12,707,447 in state general funds and $12,707,447 in non-general funds would be needed in the initial year to fund a 25 percent reimbursement rate increase for MR waiver residential support models of four beds or less;

(e) $4,325,000 in state general funds and $4,325,000 in non-general funds annually would be needed to fund 125 MR waiver slots per year for persons living in institutional settings and $500,000 annually to provide residential and day support start-up funds;

(f) $6,417,767 in state general funds and $6,417,767 in non-general funds would be needed to fund the initial year of an annual cost of living rate adjustment for all MR waiver services;

(g) $6,818,602 in state general funds and $6,818,602 in non-general funds would be needed to fund the initial year of an increase in MR waiver reimbursement rates for skilled nursing to approximate the private insurance rate;

(h) $47,367,180 in state general funds and $47,367,180 in non-general funds would be needed each year to apply a tiered reimbursement system for MR waiver residential services to permit a high intensity rate classification;

(i) $617,400 in state general funds and $617,400 in non-general funds would be needed to develop a “nurse monitoring” service to provide a liaison between physicians and direct support staff;

(j) $300,000 in state general funds and $300,000 in non-general funds would be needed each year to reimburse behavioral consultants for direct intervention services and reimburse behavioral consultants and skilled nursed for plan development and related expenses each year;

(k) $755,942 in state general funds and $755,942 in non-general funds would be needed each year to add dental as a covered Medicaid waiver service for adults;

(l) $18,021,072 in state general funds and $18,021,072 in non-general funds would be needed each year to funding MR waiver regulatory modifications that would permit billing for monitoring the health and safety of individuals overnight and while engaging in other less structured activities;

(m) $221,952 would be needed in the initial year to adjust the MR waiver rate for individual supported employment to approximate Department of Rehabilitative Services (DRS) rates;

(n) $125,000 would be needed each year to train direct care staff through the College of Direct Support;

(o) $100,000 would be needed each year to fund the training and endorsement of providers in Positive Behavioral Supports;

(p) $600,000 in state general funds and $225,000 (annualized) would be needed to increase the Department's Licensing Office by 2 FTEs, the Office of Human Rights by 3 FTEs, and Office of Mental Retardation by 3 FTEs and to increase the Department of Medical Assistance Services (DMAS) Quality Management Review staff by 3 FTEs;

(q) $60,000 in state general funds and $60,000 in non-general funds (annualized) would be needed to add a position in the Department that is qualified at the level of a psychiatrist; and

(r) $575,000 in state general funds and $575,000 in non-general funds would be needed each year to fund a mobile special behavioral unit that includes the services of a psychiatrist or licensed doctoral level psychologist.

Forensic Services: The Department estimates that to fully implement the "Sequential Intercept" approach developed by experts leading the national initiative to improve mental health treatment for individuals with justice system involvement would require $25,000,000 annually:

(a) $1,000,000 (annualized) would be needed statewide to provide community-based pre-arrest and booking interventions in lieu of arrest and booking interventions;

(b) $15,000,000 (annualized) would be needed statewide to fund jail diversion wraparound services, medications, and supports such as transitional housing and disability benefits that individuals with mental illness need for successful diversion from long-term incarceration and integration into the community;

(c) $9,000,000 (annualized) would be needed statewide to expand jail-based treatment services and provide release-planning capability to link individuals with serious mental illnesses with community services upon their release from incarceration.

Unmet Community Services Needs (Waiting Lists): To support the provision of community mental health, mental retardation, and substance abuse day support, employment, and residential services to adults and adolescents or children on CSB waiting lists for those services, $183,300,000 (annualized) would be needed. Resource requirements by program area follow: $27,800,000 (annualized) to serve individuals on MH waiting lists; $147,700,000 (annualized) to serve individuals on MR waiting lists; and $7,800,000 (annualized) to serve individuals on SA waiting lists.

Eastern State Hospital Transformation Initiative – Phase 2*:* Funds totaling $5,000,000 would be needed to fund a range of community mental health services and supports to divert individuals from admission to Eastern State Hospital and to facilitate the discharge of patients who can be served in community settings.

Behavioral Health Services for Veterans: A substantial increase in behavioral health service capacity within Virginia will be needed to address a defined surge in demand for services among veterans of post-9/11 deployments. To generate increased behavioral health service capacity across all CSBs, $26,700,000 would be required to hire and train clinicians and case managers, develop crisis stabilization beds, and organize proactive treatment teams based on priorities determined from the specific needs of the veteran demographic. The Department projects that behavioral health service delivery costs for this population will exceed $8,000,000 within three years and will grow steadily over a 15 year period before stabilizing.

Suicide Prevention Plan Implementation: In 2005, the Department assumed lead agency responsibility for the implementation of the *Suicide Prevention Across the Lifespan for the Commonwealth of Virginia* (see Senate Document 17, 2004). Suicide continues as a pubic health problem and far more lives are lost to suicide than homicide in Virginia; funds have not been allocated to implement the recommendations contained in this plan. Funds totaling $3,000,000 (annualized) would be needed to implement this plan.

System Transformation Training and Development: Workforce and organizational development activities are fundamental to supporting and sustaining Virginia's services system transformation initiative. The Department has no capacity to advance comprehensive, ongoing training, technical assistance, and consultation required for successful implementation of programs that incorporate recovery values and principles and best practices. Academic institutions have served as important drivers of mental health system changes in states such as Ohio, Kansas, and Connecticut. Funds totaling $550,000 (annualized) would be needed to establish partnerships with one or more Virginia universities to develop "Centers of Excellence" to advance values, principles, and practices that support self-determination and recovery across the services system and to train and certify CSB staff and relevant partners involved in the involuntary civil commitment process.

Direct Service Associate and Nursing Professional Career Pathways: Funds totaling $4,000,000 would be needed to implement workforce initiatives for direct service associates and nursing staff. The Department employs over 3,700 direct service associates who serve as the front line support staff at the 16 state facilities. A career pathway program, utilizing the College of Direct Support and the community college system, would elevate the level of service provided by these staff. This program also would establish a career ladder for state facility registered nurses with four levels ranging from novice to expert. For each level, nurse practice would be evaluated using standards for clinical skills and knowledge, advancing nursing practice, therapeutic relationships, professional development, and professional relationships.

State Facility Cost of Living Adjustment*:* Funds totaling $3,400,000 (annualized) would be needed to provide a four percent adjustment to offsets higher operational (non-personnel) costs in state facilities.

Northern Virginia State Facility Workforce Shortages: Workforce shortages in the local labor market, significant gaps between market competitors' and state salaries, and the escalating cost of living in Northern Virginia have combined to adversely affect the ability of the two state facilities in the region to recruit and retain mission-critical positions. Compensation reform tools, contemporary leadership practices, and other creative strategies have not overcome these issues. Funds totaling $3,650,000 would be needed to grant salary adjustments to employees in positions with the highest market variance, turnover and vacancy and turnover rates, and the length of time required to fill vacancies at these two state facilities.

Virginia Center for Behavioral Rehabilitation Operations*:* Funds totaling $6,300,000 (annualized) would be needed to operate at the projected increased capacity at the new facility.

Multicultural Competency: Funds totaling $200,000 (annualized) are needed to develop and support a coordinated approach for achieving a diverse workforce and providing culturally competent supports, training providers to more effectively address the needs of diverse communities, and improving access to services for people from different cultures.

Electronic Health Records: Funds totaling $2,500,000 (annualized) would be needed to realize the third phase of the Department's electronic health records initiative in state facilities. This phase involves the purchase and implementation of a comprehensive behavioral healthcare clinical records application.

VII. CONCLUSION

This document responds to the requirement in §37.2-315 of the *Code of Virginia* for a six-year Comprehensive State Plan for mental health, mental retardation, and substance abuse services that identifies the services and supports needs of persons with mental illnesses, mental retardation, or substance use disorders across the Commonwealth; defines resource requirements; and proposes strategies to address these needs. The directions established in the *Comprehensive State Plan for 2008-2014* would enable the Commonwealth to accelerate the transformation of the public services system to a more completely community-based system of care while preserving the important roles and service responsibilities of state hospitals and training centers in Virginia's publicly funded services system.

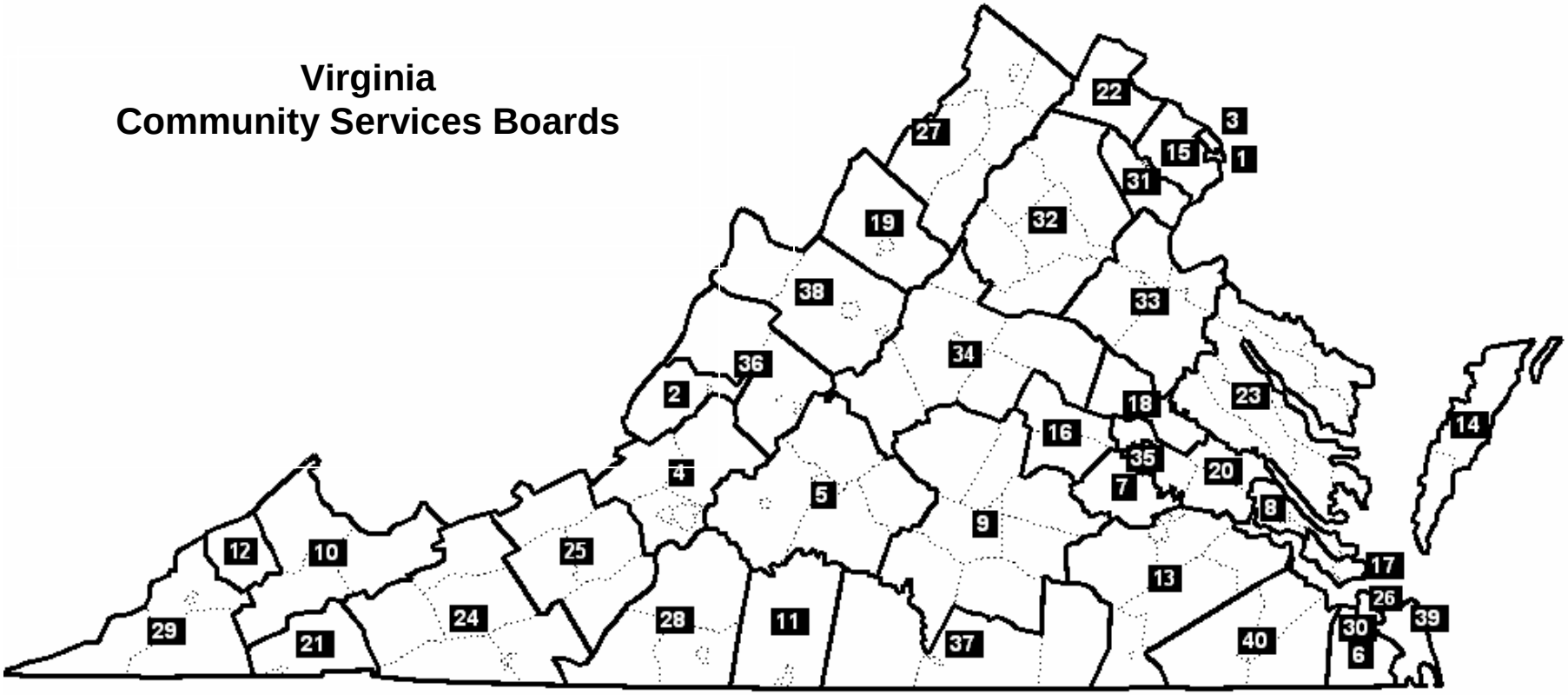
The *Comprehensive State Plan for 2008-2014* continues the direction set forth in previous *Comprehensive State Plans* to increase community options and individual choice; support opportunities for individual and family member education, training, and participation; promote collaborative activities with other agencies and services systems and private sector development; improve services oversight and accountability; advance quality improvement and care coordination; and address system administrative and infrastructure issues.

The policy agenda for publicly funded mental health, mental retardation, and substance abuse services for the next biennium continues to focus, to the extent possible, on two key themes:

- Sustaining the progress that has been achieved during the past four years in implementing the vision for the future mental health, mental retardation, and substance abuse services system, and
- Investing in services capacity and infrastructure needed to address issues facing the services system.

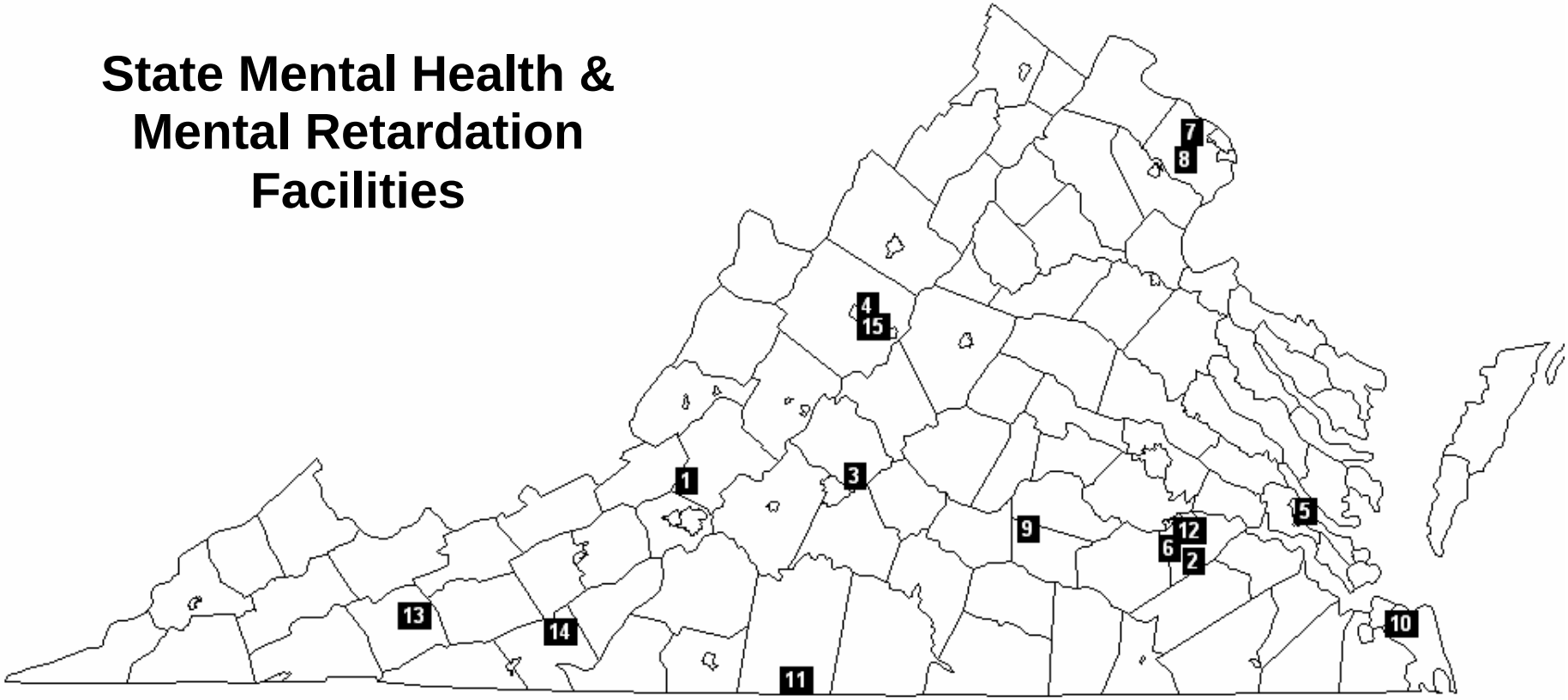
Appendix A

Maps of Community Services Board Service Areas and State Mental Health and Mental Retardation Facility Locations



1	Alexandria	11	Danville-Pittsylvania	21	Highlands	31	Prince William
2	Alleghany Highlands	12	Dickenson	22	Loudoun	32	Rappahannock-Rapidan
3	Arlington	13	District 19	23	Mid Peninsula-Northern Neck	33	Rappahannock Area
4	Blue Ridge	14	Eastern Shore	24	Mount Rogers	34	Region Ten
5	Central Virginia	15	Fairfax-Falls Church	25	New River Valley	35	Richmond
6	Chesapeake	16	Goochland-Powhatan	26	Norfolk	36	Rockbridge Area
7	Chesterfield	17	Hampton-Newport News	27	Northwestern	37	Southside
8	Colonial	18	Hanover	28	Piedmont	38	Valley
9	Crossroads	19	Harrisonburg-Rockingham	29	Planning District 1	39	Virginia Beach
10	Cumberland Mountain	20	Henrico Area	30	Portsmouth	40	Western Tidewater

State Mental Health & Mental Retardation Facilities



	Facility	Location
1	Catawba Hospital	Catawba
2	Central State Hospital	Petersburg
3	Central VA Training Center	Madison Heights
4	Commonwealth Ctr. for Children & Adolescents	Staunton
5	Eastern State Hospital	Williamsburg
6	Hiram W. Davis Medical Center	Petersburg
7	Northern VA MH Institute	Falls Church
8	Northern VA Training Center	Fairfax

	Facility	Location
9	Piedmont Geriatric Hospital	Burkeville
10	Southeastern VA Training Center	Chesapeake
11	Southern VA Mental Health Institute	Danville
12	Southside VA Training Center	Petersburg
12a	Behavioral Rehabilitation Center	Petersburg
13	Southwestern VA MH Institute	Marion
14	Southwestern VA Training Center	Hillsville
15	Western State Hospital	Staunton

Appendix B
Community Services Board Services Utilization and Condensed Core Services Taxonomy 7 Definitions

Community services boards (CSBs) offer varying combinations of nine core services, directly and through contracts with other organizations. Table 1 displays trends in numbers of consumers served between state FY 1988 and FY 2006 by program area. Tables 2 through 5 display information about static capacities and units of service provided in state FY 2006, which started on July 1, 2005 and ended on June 30, 2006. All tables show actual data, derived from annual community services performance contract reports submitted by CSBs.

Table 1: Consumers Served by CSBs[1]

FY	Mental Health		Mental Retardation		Substance Abuse		TOTAL	
	Undupl.[2]	Dupl.[3]	Undupl.[2]	Dupl.[3]	Undupl.[2]	Dupl.[3]	Undupl.[2]	Dupl.[3]
1988	110,082	161,033	14,354	22,828	57,363	80,138	181,799	263,999
1989	107,892	157,825	17,361	27,610	62,905	87,878	188,158	273,313
1990	NA	152,811	NA	30,198	NA	101,816	NA	284,825
1991	NA	161,536	NA	28,539	NA	103,288	NA	293,363
1992	NA	160,115	NA	27,525	NA	78,358	NA	265,998
1993	105,389	158,115	19,010	27,696	55,871	80,271	180,270	266,082
1994	107,131	168,208	19,742	28,680	59,471	87,166	186,344	284,054
1995	106,637	177,320	18,572	29,141	61,463	88,471	186,672	294,932
1996	116,344	174,126	19,169	30,006	64,309	90,750	199,822	294,882
1997	115,169	179,500	20,557	30,655	63,040	90,099	198,766	300,254
1998	119,438	185,647	20,983	32,509	68,559	96,556	208,980	314,712
1999	112,729	178,334	21,772	33,087	64,899	93,436	199,400	304,857
2000	118,210	180,783	22,036	26,086	61,361	88,358	201,607	295,227
2001	105,169	178,254	23,843	33,238	59,968	102,037	188,980	313,529
2002	107,351	176,735	24,903	33,933	59,895	91,904	192,149	302,572
2003	109,025	180,110	25,207	34,103	57,526	86,979	191,758	301,102
2004	109,175	181,396	23,925	35,038	53,854	78,008	186,954	294,442
2005	115,173	188,289	26,050	39,414	53,909	76,141	195,132	303,844
2006	118,732	195,794	26,893	36,004	52,416	73,633	198,041	305,431

NOTES:

1 Unduplicated counts of consumers were not collected by the Department every year. The NA notations show years in which this information was not collected.

2 Unduplicated (**Undupl.**) numbers of individuals are the total number of consumers receiving services in a program (mental health, mental retardation, or substance abuse services) area, regardless of how many services they received. If a person with a dual diagnosis (e.g., mental illness and substance use disorder) received services in both program areas, he or she would be counted twice.

3 Duplicated (**Dupl.**) numbers of individuals are the total numbers of consumers receiving each category or subcategory of core services. Thus, if a person received outpatient, rehabilitation, and supervised residential services, he would be counted three times, since he received three core services. These totals are added to calculate a total number of consumers served for each program area.

With the implementation in FY 2004 of the Community Consumer Submission (software that extracts individual consumer data from CSB information systems and transmits encrypted data to the Department) a totally unduplicated count of consumers at the CSB across all program areas, rather than in each program area is available for the first time. In FY 2006, 176,276 individuals received services from the CSBs. The difference between that figure and the sum of the unduplicated number of consumers in each program area, shown in the preceding table, gives some indication of the numbers of consumers who may be receiving services in more than one program area: 21,765 individuals in FY 2006.

Table 2: FY 2006 CSB Mental Health Core Services Static Capacities			
Core Service	**Capacity**	**Core Service**	**Capacity**
Local Inpatient Services	58.10 beds	Supported Employment - Group Models	29.61 slots
TOTAL Local Inpatient Services	58.10 beds	**TOTAL Employment Services**	65.61 slots
Day Treatment/Partial Hospitalization	1,208.00 slots	Highly Intensive Residential Services	107.65 beds
Rehabilitation Services	2,254.07 slots	Intensive Residential Services	158.40 beds
TOTAL Day Support Services	3,462.07 slots	Supervised Residential Services	863.50 beds
Sheltered Employment Services	36.00 slots	**TOTAL Residential Services**	1,129.55 beds

Note: Decimal fractions of beds and slots result from calculating these capacities for contracted services where a CSB purchases a number of bed days or days of service, which must be converted to numbers of beds or day support slots.

Table 3: FY 2006 CSB Mental Retardation Core Services Static Capacities			
Core Service	**Capacity**	**Core Service**	**Capacity**
Rehabilitation Services	2,029.20 slots	Highly Intensive Residential Services	98.00 beds
Sheltered Employment Services	837.48 slots	Intensive Residential Services	810.00 beds
Supported Employment - Group Models	661.00 slots	Supervised Residential Services	464.75 beds
TOTAL Day Support Services	3,527.68 slots	**TOTAL Residential Services**	1,372.75 beds

Note: Decimal fractions of beds and slots result from calculating these capacities for contracted services where a CSB purchases a number of bed days or days of service, which must be converted to numbers of beds or day support slots.

Table 4: FY 2006 CSB Substance Abuse Core Services Static Capacities			
Core Service	**Capacity**	**Core Service**	**Capacity**
Local Inpatient Services	4.77 beds	SA Social Detoxification Services	113.06 beds
Community Hospital-Based Detox.	36.30 beds	Intensive Residential Services	525.36 beds
TOTAL Local Inpatient Services	41.07 beds	Jail-Based Habilitation Services	385.00 beds
Day Treatment/Partial Hospitalization	227.10 slots	Supervised Residential Services	121.01 beds
TOTAL Day Support Services	227.10 slots	**TOTAL Residential Services**	1,144.43 beds

Note: Decimal fractions of beds and slots result from calculating these capacities for contracted services where a CSB purchases a number of bed days or days of service, which must be converted to numbers of beds or day support slots.

Table 5: FY 2006 CSB Services Provided by Core Service				
Program Area→ **Core Service/Unit of Service ↓**	**MH**	**MR**	**SA**	**TOTAL**
1. Emergency Provider Service Hours	356,796	1,385	44,946	403,127
2. Local Inpatient Services				
Local Inpatient Services	20,348		4,122	24,470
Community Hospital-Based Detox			7,483	7,483
TOTAL Local Inpatient Bed Days	20,348		11,605	31,953
3. Outpatient Services				
Outpatient Services	1,042,613	1,129	479,381	1,523,123
Opioid Detoxification Services			20,719	20,719
Opioid Treatment Services			82,936	82,936
Assertive Community Treatment	219,431			219,431
TOTAL Outpatient Provider Service Hours	1,262,044	1,129	583,036	1,846,209
4. Case Management Provider Service Hours	990,227	566,159	155,214	1,711,600
5. Day Support Services				
Day Treatment/Partial Hospitalization	1,056,982		291,790	1,348,772
Rehabilitation/Habilitation	2,770,850	2,131,035		4,901,885
TOTAL Day Support Hours	3,827,832	2,131,035	291,790	6,250,657
6. Employment Services				
Sheltered Employment Services	6,748	174,951		181,699
Supported Employment - Group Models	4,275	130,901		135,176
TOTAL Day Support Days of Service	11,023	305,852		316,875
Supported/Transitional Employment	28,720	92,077		120,797
TOTAL Day Support Hours	28,720	92,077		120,797
7. Residential Services				
Highly Intensive Residential Services	24,215	30,252		54,467
Intensive Residential Services	54,892	261,707	143,738	460,337
Jail-Based Habilitation Services			159,894	159,894
Supervised Residential Services	255,020	104,822	31,405	391,247
TOTAL Residential Bed Days	334,127	396,781	335,037	1,065,945
Supportive Residential Services	567,990	910,840	15,295	1,494,125
TOTAL Residential Provider Service Hours	567,990	910,840	15,295	1,494,125
8. Prevention and Early Intervention Services				
Prevention Services	44,113	7,059	245,784	296,956
Early Intervention Services	12,489	271,567	23,999	308,055
TOTAL Prevention & E.I. Provider Service Hours	56,602	278,626	269,783	605,011
9. Limited Services				
Substance Abuse Social Detoxification Bed Days			21,114	21,114
Substance Abuse Motivational Treatment Services	16		2,779	2,795
Consumer Monitoring Services	28,465	14,100	7,373	49,938
Assessment and Evaluation Services	26,831	2,106	10,803	39,740
TOTAL Limited Services Provider Service Hours	55,312	16,206	20,955	92,473

Table 6: FY 2006 Unduplicated Numbers of Consumers Served by Age and Gender by Program Area (MH, MR, or SA Services)									
Age	Mental Health Services			Mental Retardation Services			Substance Abuse Services		
	Male	Female	Unknown	Male	Female	Unknown	Male	Female	Unknown
0-2	500	374	7	5,994	3,699	14	79	61	3
3-12	7,967	4,388	34	1,114	650	3	425	249	1
13-17	7,333	6,478	33	795	530	5	4,314	2,125	11
18-22	4,704	4,135	22	1,304	922	5	4,541	1,987	14
23-59	33,920	37,909	120	5,857	4,913	14	24,454	13,067	54
60-64	1,444	2,300	1	210	229	0	284	114	0
65-74	1,365	2,278	4	213	231	0	171	57	0
75+	852	1,628	5	65	49	0	27	30	3
Unknown	161	201	569	12	9	56	98	40	207
Subtotal	58,246	59,691	795	15,564	11,232	97	34,393	17,730	293
Total	118,732			26,893			52,416		

Table 7: FY 2006 Unduplicated Numbers of Consumers Served by Race and Gender by Program Area (MH, MR, or SA Services)									
Program Area → Race↓	MH Services			MR Services			SA Services		
	Male	Female	Unk	Male	Female	Unk	Male	Female	Unk
Alaska Native	31	39	0	13	6	0	12	10	0
American Indian	177	149	1	21	25	0	114	61	0
American Indian or Alaska AND Black or African American	17	20	0	0	1	0	23	8	0
American Indian or Alaska Native AND White	33	39	0	6	2	0	33	21	0
Asian	134	171	0	76	66	1	69	31	0
Asian AND White	30	48	0	14	6	0	34	17	0
Asian or Pacific Islander	555	600	1	319	245	0	259	74	0
Black or African American AND White	308	314	0	51	44	0	164	66	0
Black or African American	17,647	15,937	44	4,075	2,998	7	10,923	5,167	16
Native Hawaiian or Other Pacific Islander	14	20	0	7	1	0	9	4	0
Other Multi-Race	160	154	1	45	31	0	76	40	1
Other	2,445	2,667	12	913	648	2	2,533	659	2
White	35,886	38,571	60	9,497	6,816	8	19,708	11,325	26
Unknown/ Not Collected	809	962	676	527	343	79	436	247	248
Subtotal	58,246	59,691	795	15,564	11,232	97	34,393	17,730	293
Total	118,732			26,893			52,416		

CONDENSED CORE SERVICES TAXONOMY 7
SERVICE DEFINITIONS

Note: *Italicized services* (e.g., *Intensive In-Home Services* in **OUTPATIENT SERVICES**, *Therapeutic Day Treatment for Children and Adolescents* in ***Day Treatment/Partial Hospitalization***, or *Group Homes or Halfway Houses* in ***Intensive Residential Services***) that are not in **bold type** in the following core services definitions are carried over from Core Services Taxonomy 6 only for illustrative purposes; they are not additional core services subcategories. Information about numbers of consumers served, units of services, and expenses are projected and reported only at the core services category or subcategory level.

EMERGENCY SERVICES are unscheduled and sometimes scheduled crisis intervention, stabilization, and referral assistance provided over the telephone or face-to-face, if indicated, 24 hours per day and seven days per week, to people seeking such services for themselves or others. Services also may include walk-ins, home visits, and jail interventions. Emergency Services include preadmission screening or other activities that prevent admission to a mental health hospital or mental retardation training center or are associated with the judicial admission process. This category includes discharge planning for consumers in acute local and state hospital inpatient services. Discharge planning for consumers in state hospital extended rehabilitation services and for Discharge Assistance Project consumers is provided in case management services. Emergency Services also include Medicaid Crisis Intervention and Short-Term Crisis Counseling and Mental Retardation Home and Community-Based (MRHCB) Waiver Crisis Stabilization and Personal Emergency Response System Services.

LOCAL INPATIENT SERVICES deliver services on a 24-hour-per-day basis in a hospital setting.

- ***Acute Psychiatric or Substance Abuse Services*** provide intensive short-term psychiatric treatment in state hospitals and provide intensive short-term psychiatric treatment, including services to persons with mental retardation, or substance abuse treatment, except detoxification, in local hospitals. Services include intensive stabilization, evaluation, psychotropic medications, psychiatric and psychological services, and other supportive therapies provided in a highly structured and supervised setting.
- ***Community-Based Substance Abuse Medical Detoxification Inpatient Services*** use medication under the supervision of medical personnel in local hospitals or other 24 hour per day care facilities to systematically eliminate or reduce the effects of alcohol or other drugs in the body.

OUTPATIENT SERVICES provide clinical treatment services, generally in sessions of less than three consecutive hours, to individuals and groups.

- ***Outpatient Services*** are generally provided to consumers on an hourly schedule, on an individual, group, or family basis, and usually in a clinic or similar facility or in another location. Outpatient Services may include diagnosis and evaluation, screening and intake, counseling, psychotherapy, behavior management, psychological testing and assessment, laboratory and other ancillary services, medical services, and medication services. Medical services include the provision of psychiatric, medical, psychiatric nursing, and medical nursing services by licensed psychiatrists, physicians, and nurses and the cost of medications purchased by the CSB and provided to consumers. Medication services include prescribing and dispensing medications, medication management, and pharmacy services. Medication only visits include only consumers who receive only medication monitoring on a periodic (monthly or quarterly) basis from a psychiatrist, other MD, psychiatric nurse, or physician's assistant. These visits are included in Outpatient Services. The Department has identified a minimum set of information for licensing purposes that would be needed to constitute an individualized services plan (ISP) for medication only consumers.

  Outpatient Services also include *Intensive Substance Abuse Outpatient Services* that are provided generally in a concentrated manner over a four to 12 week period for consumers who require intensive outpatient stabilization, such as people with severe psychoactive substance use disorders. Usually, intensive outpatient services include multiple group therapy sessions during the week plus individual and family therapy, consumer monitoring, and case management.

  Outpatient Services also include *Intensive In-home Services* that are time-limited, usually between two and six months, family preservation interventions for children and adolescents with or at risk of serious emotional disturbance, including such individuals who also have a diagnosis of mental retardation. In-home services are provided typically but not solely in the residence of an individual who is at risk of being moved into or who is being transitioned to home from an out-of-home placement. These services provide crisis treatment; individual and family counseling; life, parenting, and communication skills; case management activities and coordination with other required services; and 24 hour per day emergency response.

  Finally, Outpatient Services also include Medicaid MRHCB Waiver Skilled Nursing Services and Therapeutic Consultation

Services. Probation and Parole and Community Corrections Day Reporting Centers also are included in Outpatient Services, rather than in Limited Services.

- ***Opioid Detoxification Services*** combine outpatient treatment with administering or dispensing synthetic narcotics, such as methadone, approved by the federal Food and Drug Administration as a substitute for opioid substances, such as heroin or other narcotic drugs, in decreasing doses to reach a drug-free state in a period not to exceed 180 days.

- ***Opioid Treatment Services*** combine outpatient treatment with administering or dispensing synthetic narcotics, such as methadone, approved by the federal Food and Drug Administration for the purpose of replacing the use of and reducing the craving for opioid substances, such as heroin or other narcotic drugs.

- ***Assertive Community Treatment*** includes two modalities, Intensive Community Treatment (ICT) and Programs of Assertive Community Treatment (PACT). Individuals served by either modality have severe symptoms and impairments that are not effectively remedied by available treatments or, because of reasons related to their mental illnesses, resist or avoid involvement with mental health services. This could include individuals with severe and persistent mental illnesses who also have co-occurring diagnoses of mental retardation. Assertive Community Treatment provides an array of services on a 24-hour per day basis to these individuals in their natural environments to help them achieve and maintain effective levels of functioning and participation in their communities. Services may include case management; supportive counseling; symptom management; medication administration and compliance monitoring; crisis intervention; developing individualized community supports; psychiatric assessment and other services; and teaching daily living, life, social, and communication skills.

  Intensive Community Treatment is provided by a self-contained, interdisciplinary team of at least five full-time equivalent clinical staff, a program assistant, and a psychiatrist that (1) assumes responsibility for directly providing needed treatment, rehabilitation, and support services to identified individuals with severe and persistent mental illnesses; (2) minimally refers individuals to outside service providers; (3) provides services on a long-term care basis with continuity of caregivers over time; (4) delivers 75 percent or more of the services outside of the program's offices; and (5) emphasizes outreach, relationship building, and individualization of services.

  Program of Assertive Community Treatment is provided by a self-contained, inter-disciplinary team of at least 10 full-time equivalent clinical staff, a program assistant, and a psychiatrist that meets the five criteria contained in the definition of *Intensive Community Treatment*.

CASE MANAGEMENT SERVICES assist individuals and their family members to access needed services that are responsive to the person's individual needs. Services include: identifying and reaching out to potential consumers; assessing needs and planning services; linking the individual to services and supports; assisting the person directly to locate, develop or obtain needed services and resources; coordinating services with other providers; enhancing community integration; making collateral contacts; monitoring service delivery; and advocating for people in response to their changing needs.

DAY SUPPORT SERVICES provide structured programs of treatment, activity, or training services, generally in clusters of two or more continuous hours per day, to groups or individuals in non-residential settings.

- ***Day Treatment/Partial Hospitalization*** is a treatment program that includes the major diagnostic, medical, psychiatric, psychosocial, and prevocational and educational treatment modalities designed for adults with serious mental illnesses or substance use disorders who require coordinated, intensive, comprehensive, and multi-disciplinary treatment of pathological conditions that is not provided in outpatient services.

  Day Treatment/Partial Hospitalization also includes *Therapeutic Day Treatment for Children and Adolescents*, a treatment program that serves children and adolescents (birth through age 17) with serious emotional disturbances or at risk of serious emotional disturbance in order to combine psychotherapeutic interventions with education and mental health treatment. Services include: evaluation, medication education and management, opportunities to learn and use daily living skills and to enhance social and interpersonal skills, and individual, group, and family counseling.

- ***Rehabilitation/Habilitation*** includes training opportunities in two modalities.

  Psychosocial Rehabilitation provides assessment, medication education, opportunities to learn and use independent living skills and to enhance social and interpersonal skills, family support and education, vocational and educational opportunities, and advocacy in a supportive community environment focusing on normalization. It emphasizes strengthening the person's abilities to deal with everyday life rather than focusing on treating pathological conditions.

  Habilitation provides planned combinations of individualized activities, supports, training, supervision, and transportation to individuals with mental retardation to improve their condition or maintain an optimal level of functioning. Specific components

of this service develop or enhance the following skills: self-care and hygiene, eating, toileting, task learning, community resource utilization, environmental and behavioral skills, medication management, and transportation.

Rehabilitation/Habilitation also includes *Alternative Day Support Arrangements* that assist people to locate day support settings and may provide program staff, follow along, or assistance to these individuals with a focus on assisting the person to maintain an independent day support arrangement and *Education/Recreation Services* that provide education, recreation, enrichment, and leisure activities daily, weekly, or monthly, during the summer or throughout the year. Habilitation also includes Medicaid MRHCB Waiver Day Support (Center-Based and Non-Center- Based) and Prevocational Services.

EMPLOYMENT SERVICES provide work and support services to groups or individuals in non-residential settings.

- ***Sheltered Employment*** programs provide work in a non-integrated setting that is compensated in accordance with the Fair Labor Standards Act for individuals with disabilities who are not ready, are unable, or choose not to enter into competitive employment in an integrated setting. This service includes the development of social, personal, and work-related skills based on an individualized consumer service plan.
- ***Group Supported Employment*** provides work to small groups of three to eight individuals at job sites in the community or at dispersed sites within an integrated setting. Integrated setting means opportunities exist for consumers in the immediate work setting to have regular contact with non-disabled individuals who are not providing support services. The employer or the vendor of supported employment services employs the consumers. An employment specialist, who may be employed by the employer or the vendor, provides ongoing support services. Support services are provided in accordance with the consumer's individual written rehabilitation plan. Models include mobile and stationary crews, enclaves, and small businesses. Group Supported Employment includes Medicaid MRHCB Waiver Supported Employment - Group Model.
- ***Individual Supported Employment*** provides paid employment to a consumer placed in an integrated work setting in the community. The employer employs the consumer. On-going support services that may include transportation, job-site training, counseling, advocacy, and any other supports needed to achieve and to maintain the consumer in the supported placement are provided by an employment specialist, co-workers of the supported employee, or other qualified individuals. Support services are provided in accordance with the consumer's individual written rehabilitation plan.

  Individual Supported Employment also includes *Transitional Employment* services that involve a sequence of temporary supported placements that result in a final competitive employment placement with or without supports. Service units may be included here or as part of another program, such as psychosocial rehabilitation, depending on how the service is delivered and its relative volume. Individual Supported Employment includes Medicaid MR HCB Waiver Supported Employment - Individual Model.

RESIDENTIAL SERVICES provide overnight care with an intensive treatment or training program in a setting other than a hospital or training center, overnight care with supervised living, or other supportive residential services.

- ***Highly Intensive Residential Services*** provide **overnight care with intensive treatment or training services**. These services include: mental health residential treatment centers such as short term intermediate care, crisis stabilization, residential alternatives to hospitalization, and residential services for individuals with dual diagnoses (e.g., mental retardation with co-occurring mental illness) where intensive treatment rather than just supervision occurs and Intermediate Care Facilities for Mentally Retarded persons (ICF/MR) that deliver active habilitative and training services in a community setting. This subcategory also includes *Community Gero-psychiatric Residential Services* that provide 24-hour non-acute care with treatment in a setting that offers less intensive services than a hospital, but more intensive mental health services than a nursing home or group home. Individuals with mental illness, behavioral problems, and concomitant health problems, usually age 65 and older, who are appropriately treated in a geriatric setting, receive intense supervision, psychiatric care, behavioral treatment planning, nursing, and other health-related services.
- ***Intensive Residential Services*** provide **overnight care with treatment or training that is less intense than highly intensive residential services**. It includes the following services and Medicaid MRHCB Waiver Congregate Residential Support Services.

  Primary Care offers substance abuse rehabilitation services that normally last no more than 30 days. Services include intensive stabilization, daily group therapy and psychoeducation, consumer monitoring, case management, individual and family therapy, and discharge planning.

  Intermediate Rehabilitation is a substance abuse psychosocial therapeutic milieu with an expected length of stay up to 90 days. Services include supportive group therapy, psycho-education, consumer monitoring, case management, individual and family

therapy, employment services, and community preparation services.

Long-Term Habilitation is a substance abuse psychosocial therapeutic milieu with an expected length of stay of 90 or more days that provides a highly structured environment where residents, under staff supervision, are responsible for daily operations of the facility. Services include intensive daily group and individual therapy, family counseling, and psycho-education. Daily living skills and employment opportunities are integral components of the treatment program.

Group Homes or Halfway Houses are facilities that provide identified beds and 24 hour supervision for individuals who require training and assistance in basic daily living functions such as meal preparation, personal hygiene, transportation, recreation, laundry, and budgeting. The expected length of stay normally exceeds 30 days.

- ***Jail-Based Habilitation Services*** offer a substance abuse psychosocial therapeutic community with an expected length of stay of 90 days or more that provides a highly structured environment where residents, under staff and correctional supervision, are responsible for the daily operations of the program. Services include intensive daily group counseling, individual therapy, psycho-educational services, 12 step meetings, discharge planning, and pre-employment and community preparation services. Daily living skills in conjunction with the therapeutic milieu structure are an integral component of the treatment program. Normally, inmates served by this program are housed separately within the jail.

- ***Supervised Residential Services*** offer **overnight care with supervision and services**. This subcategory includes the following services and Medicaid MRHCB Waiver Congregate Residential Support Services.

  Supervised Apartments are directly operated or contracted, licensed or unlicensed, residential programs that place and provide services to individuals in apartments or other residential settings. The expected length of stay normally exceeds 30 days.

  Domiciliary Care provides food, shelter, and assistance in routine daily living but not treatment or training in facilities of five or more beds. This is primarily a long-term setting with an expected length of stay exceeding 30 days. Domiciliary care is less intensive than a group home or supervised apartment; an example would be a licensed assisted living facility (ALF) funded or contracted by a CSB.

  Emergency Shelter or Residential Respite programs provide identified beds, supported or controlled by a CSB, in a variety of settings reserved for short term stays, usually several days to no more than 21 consecutive days.

  Sponsored Placements place people in residential settings and provide substantial amounts of financial, programmatic, or service support. Examples include individualized therapeutic homes, specialized foster care, family sponsor homes, and residential services contracts for specified individuals. The focus is on individual consumer residential placements with expected lengths of stay exceeding 30 days rather than on organizations with structured staff support and set numbers of beds.

- ***Supportive Residential Services*** are unstructured services that support individuals in their own housing arrangements. These services normally do not involve overnight care delivered by a program. However, due to the flexible nature of these services, overnight care may be provided on an hourly basis. It includes the following services and Medicaid MRHCB Waiver Supported Living/In-Home Supports, Respite (Agency and Consumer-Directed) Services, Companion Services (Agency and Consumer-Directed), and Personal Assistance Services (Agency and Consumer-Directed).

  In-Home Respite provides care in the homes of people with mental disabilities or in a setting other than that described in residential respite services above. This care may last from several hours to several days and allows the family member care giver to be absent from the home.

  Supported Living Arrangements are residential alternatives that are not included in other types of residential services. These alternatives assist people to locate or maintain residential settings where access to beds is not controlled by a CSB and may provide program staff, follow along, or assistance to these individuals. The focus may be on assisting an individual to maintain an independent residential arrangement. Examples include homemaker services, public-private partnerships, and non-CSB subsidized apartments (e.g., HUD certificates).

  Housing Subsidies provide cash payments only, with no services or staff support, to enable consumers to live in housing that would otherwise not be accessible to them. These cash subsidies may be used for rent, utility payments, deposits, furniture, and other similar payments required to initiate or maintain housing arrangements for consumers. This is used only for specific allocations of funds from the Department that are earmarked for housing subsidies. Numbers of consumers and expense information should be included in supportive residential services in the contract and reports. Information associated with other housing subsidies should be included in the services of which they are a part.

PREVENTION AND EARLY INTERVENTION SERVICES are designed to prevent or intervene early in the process of mental illness, mental retardation, or substance use disorder, including enhancing the development of handicapped or at-risk infants and toddlers. Activities should not be included in prevention or early intervention services that are really outpatient services to avoid record

keeping or licensing requirements, since this exposes the CSB to increased liability and is not clinically appropriate. School-Based Interventions should be included in Prevention, Early Intervention, or Outpatient Services, as appropriate.

- ***Prevention Services*** involve people, families, communities, and systems working together to promote their strengths and potentials. Prevention is aimed at substantially reducing the incidence of mental illness, mental retardation and other developmental disabilities, and substance use disorders. Emphasis is on enhancement of protective factors and reduction of risk factors. The following six activities comprise prevention services. Information about these activities will be collected and reported separately from the performance contract. Only units of services and expenses at the prevention services level and amounts of funds expended for each of these six activities will be projected and reported through the performance contract process.

  Information Dissemination provides awareness and knowledge of the nature and extent of mental illness, mental retardation, developmental disabilities, and substance use disorders. It also provides awareness and knowledge of available prevention programs and services. Examples of information dissemination include media campaigns, public service announcements, informational brochures and materials, community awareness events, and participation on radio or TV talk shows. Information dissemination is characterized by one-way communication from the source to the audience.

  Prevention Education aims to affect critical life and social skills, including general competency building, specific coping skills training, support system interventions, strengthening caregivers, and decision-making skills training. Prevention education is characterized by two-way communication with close interaction between the facilitator or educator and the program participants. Examples of prevention education include children of alcoholics groups and parenting classes.

  Alternatives provide for the participation of specific populations in activities that are constructive, promote healthy choices, and provide opportunities for skill building. Examples of prevention alternatives include leadership development; community service projects; alcohol, tobacco, and other drug free activities; and youth centers.

  Problem Identification and Referral aims at the identification of those individuals who are most at risk of developing problematic behaviors in order to assess if their behaviors can be changed though prevention education. Examples include student and employee assistance programs.

  Community-based Process aims at enhancing the ability of the community to provide prevention and treatment services more effectively. Activities include organizing, planning, enhancing efficiency and effectiveness of service implementation, interagency collaboration, coalition building, and networking. Examples include community and volunteer training, multi-agency coordination and collaboration, accessing services and funding, and community team-building.

  Environmental prevention activities establish or change written and unwritten community standards, codes, and attitudes, thereby influencing the development of healthy living conditions. Examples include modifying advertising practices and promoting the establishment and review of alcohol, tobacco, and other drug use policies.

  Critical Incident Stress Debriefing (CISD) services are also a form of Prevention Services, but they are not included in the preceding activities. Individuals receiving CISD services will not be admitted to the CSB, enrolled in a service, or counted as consumers. Service units will be collected through the z-consumer function in the CCS. Community outreach services, such as outreach contacts with homeless persons, are included in Prevention Services, but these individuals will not be counted as consumers; service units will be collected through the z-consumer function in the CCS.

- ***Early Intervention*** are intended to improve functioning or change behavior in those individuals identified as beginning to experience problems, symptoms, or behaviors that, without intervention, are likely to result in the need for treatment. Services are generally targeted to identified individuals or groups. Early Intervention Services include: case consultation, groups for adolescents who have been suspended for use of alcohol or tobacco, and programs for children or adults exhibiting behavior changes following loss such as divorce, death of a loved one, and job loss.

  Early Intervention Services include *Infant and Toddler Intervention*, which provides family-centered, community-based early intervention services designed to meet the developmental needs of infants and toddlers and the needs of their families as these needs relate to enhancing the child's development. These services prevent or reduce the potential for developmental delays and increase the capacity of families to meet the needs of their at-risk infants and toddlers. Infant and toddler intervention is delivered through a comprehensive, coordinated, interagency, and multi-disciplinary services system. It may include audiology, family training, counseling and home visits, health, medical, nursing, nutrition, occupational therapy, physical therapy, special instruction, psychological, speech-language pathology, vision, and transportation services. The identified consumer is the infant or toddler.

LIMITED SERVICES include the following activities that typically are short term, that is less than 30 days or four to eight sessions in

duration, or infrequent or low-intensity services and do not require collection of as many data elements through the CCS 2 or as much consumer service record information as other core services.

- ***Substance Abuse Social Detoxification Services*** are provide in specialized non-medical facilities with physician services available when required that systematically reduce or eliminate the effects of alcohol or other drugs in the body, return a person to a drug-free state, and normally last up to seven days.
- ***Substance Abuse Motivational Treatment Services*** are generally provided to consumers on an hourly basis, once per week, through individual or group counseling in a clinic. These services are structured to help consumers resolve their ambivalence about changing problematic behaviors by using a repertoire of data-gathering and feedback techniques. Motivational Treatment Services are not a part of another service; they stand alone. Their singular focus on increasing the consumer's motivation to change problematic behaviors, rather than on changing the behavior itself, distinguishes Motivational Treatment Services from Outpatient Services. A course of motivational treatment may involve a single session, but more typically four or eight sessions; and it may be repeated, if necessary, as long as repetition is clinically indicated. Prior to placement in motivational treatment, the consumer's level of readiness for change is usually assessed, based on clinical judgment, typically supported by standardized instruments. Such an assessment may also follow a course of motivational treatment to ascertain any changes in the consumer's readiness for change.
- ***Consumer Monitoring Services*** are provided to consumers who have been admitted to the CSB but who will not receive any other services. Individuals who might receive Consumer Monitoring Services include persons who have been admitted to the CSB and assigned a case manager, but they have not been enrolled in another service. Instead, they have been placed on waiting lists for services. These individuals receive no interventions or face-to-face contact in more than 180 days, but they receive Consumer Monitoring Services, which typically consist of service coordination or intermittent emergency contacts, at least once every 360 days. A consumer who is receiving nothing but family support should be enrolled in Consumer Monitoring. Also included are PATH grant outreach and support services.
- ***Assessment and Evaluation Services*** include court-ordered or psychological evaluations; initial assessments for screening, triage, and referral for individuals who probably will not continue in services; preadmission screening that does not result in hospitalization; and initial evaluations or assessments that result in placement on waiting lists without receiving other services. An abbreviated individualized services plan and consumer record may be required. Subsequently, if it is determined that an individual needs additional services, he or she would be enrolled in those services.

DEFINITIONS OF STATIC CAPACITIES

Number of Beds: the total number of beds for which the facility or program is licensed and staffed or the number of beds contracted for during the contract period.

Number of Slots: the maximum number of distinct consumers who could be served during a day or a half-day session in most day support programs. It is the number of slots for which the program or service is staffed.

Appendix C

State Mental Health and Mental Retardation Facility Utilization

State Mental Health Facility Patients Served, Average Daily Census, Admissions, and Separations -- FY 2007

MH Facility	# Patients Served	Average Daily Census	# Admissions	# Separations
Eastern State Hospital	769	427	364	369
Western State Hospital	791	241	620	615
Central State Hospital	833	240	669	666
Southwestern VA MHI	1,246	151	1,306	1,299
Northern VA MHI	747	122	775	782
Southern VA MHI	449	69	497	501
Commonwealth Center for Children and Adolescents	513	34	558	561
Catawba Hospital	343	107	284	279
Piedmont Geriatric Hospital	196	120	73	77
Hiram Davis Medical Center	163	58	108	121
Total MH	5,814*	1,569	5,254	5,270

Virginia Center for Behavioral Rehabilitation Residents Served, Average Daily Census, Admissions, and Separations -- FY2007

	# Residents Served	Average Daily Census	# Admissions	# Separations
VCBR	49	38	19	2

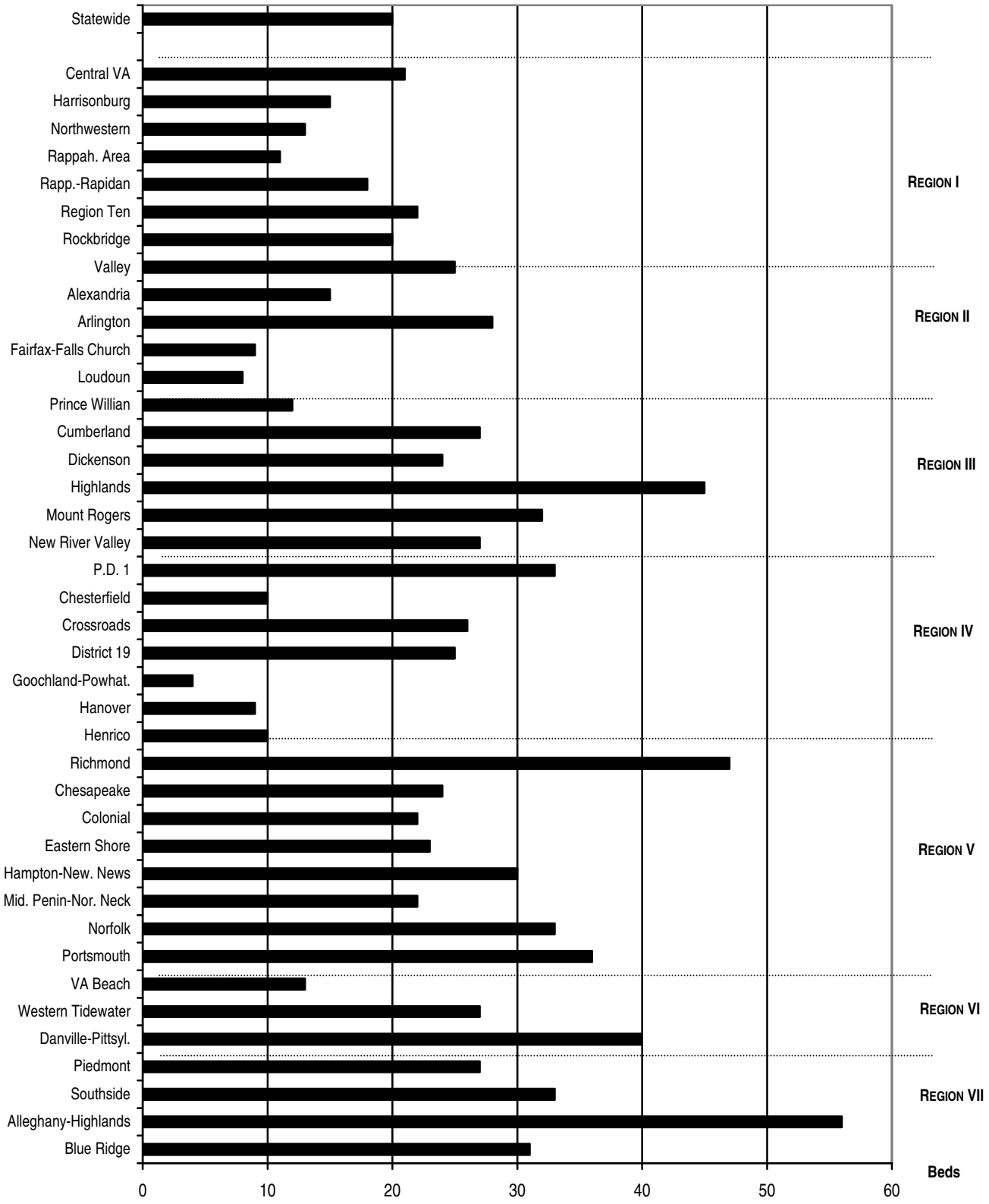
State Mental Retardation Training Center Residents Served, Average Daily Census, Admissions, and Separations -- FY2007

MR Training Center	# Residents Served	Average Daily Census	# Admissions	# Separations
Central Virginia TC	534	509	9	36
Northern Virginia TC	196	172	57	58
Southeastern Virginia TC	206	187	17	21
Southside Virginia TC	354	311	28	46
Southwestern Virginia TC	226	209	17	21
Total MR	1,512*	1,389	128	182

Source: DMHMRSAS AVATAR Information System
*Unduplicated count (unique clients) by state facility type. Total unduplicated count across all state facilities: 7,301

Total State Mental Health Facility Bed Utilization by CSB and Region FY 2007

Beds Per 100,000 Population



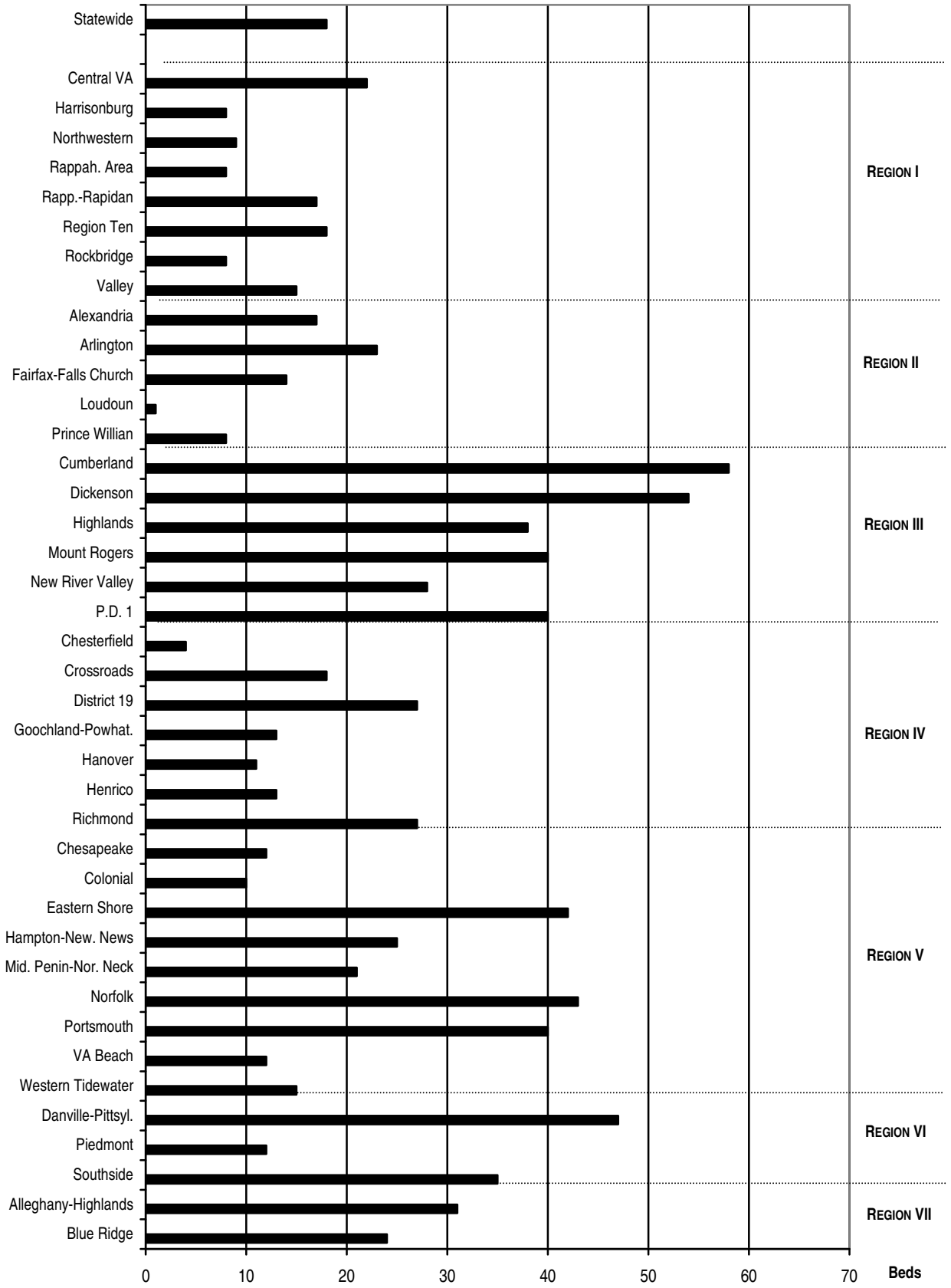
Total State Mental Health Facility Utilization by CSB and Region -- FY2007

	CSB	All Bed Days FY 2007	CSB Population	FY 2007 Bed Days Per 100 K Population	FY 2007 Beds Per 100 K Population	Beds Used
I	Central Virginia	17,776	234,140	7,592	20.80	48.70
	Harrisonburg-Rockingham	6,359	115,126	5,524	15.13	17.42
	Northwestern	9,983	206,470	4,835	13.25	27.35
	Rappahannock Area	12,017	301.831	3,981	10.91	32.92
	Rappahannock-Rapidan	10,282	156,737	6,560	17.97	28.17
	Region Ten	17,150	216,153	7,934	21.74	46.99
	Rockbridge Area	2,914	39,598	7,359	20.16	7.98
	Valley	10,414	113,797	9,151	25.07	28.53
II	Alexandria	7,056	132,176	5,338	14.63	19.33
	Arlington	19,397	191,623	10,122	27.73	53.14
	Fairfax-Falls Church	34,538	1,042,781	3,312	9.07	94.62
	Loudoun County	7,243	262,726	2,757	7.55	19.84
	Prince William County	18,150	412,894	4,396	12.04	49.73
III	Cumberland Mountain	9,553	97,305	9,818	26.90	26.17
	Dickenson County	1,399	16,226	8,622	23.62	3.83
	Highlands	11,361	69,184	16,421	44.99	31.13
	Mount Rogers	13,687	119,014	11,500	31.51	37.50
	New River Valley	16,257	167,915	9,682	26.53	44.54
	Planning District 1	11,246	93,637	12,010	32.90	30.81
IV	Chesterfield	10,410	289,568	3,595	9.85	28.52
	Crossroads	9,446	99,585	9,485	25.99	25.88
	District 19	15,621	169,419	9,220	25.26	42.80
	Goochland-Powhatan	740	45,818	1,615	4.42	2.03
	Hanover County	3,209	95,476	3,361	9.21	8.79
	Henrico Area	11,655	306,041	3,808	10.43	31.93
	Richmond BHA	33,122	191,740	17,274	47.33	90.75
V	Chesapeake	18,931	214,145	8,840	24.22	51.87
	Colonial	11,742	145,150	8,090	22.16	32.17
	Eastern Shore	4,409	52,000	8,479	23.23	12.08
	Hampton-Newport News	36,190	326,502	11,084	30.37	99.15
	Middle Pen.-Northern Neck	11,267	137,316	8,205	22.48	30.87
	Norfolk	27,896	235,071	11,867	32.51	76.43
	Portsmouth	12,926	98,514	13,121	35.95	35.41
	Virginia Beach	21,308	433,470	4,916	13.47	58.38
	Western Tidewater	13,412	137,341	9,765	26.75	36.75
VI	Danville-Pittsylvania	15,637	106,907	14,627	40.07	42.84
	Piedmont	13,414	137,922	9,726	26.65	36.75
	Southside	10,309	86,625	11,901	32.60	28.24
VII	Alleghany Highlands	4,625	22,757	20,323	55.68	12.67
	Blue Ridge	27,605	243,626	11,331	31.04	75.63
Out of State/Unknown/Unassigned		3,087	0	0	0	8.46
	VIRGINIA STATEWIDE	553,743	7,564,326	7,320.45	20.06	1,517.00

Source: DMHMRSAS AVATAR and 2005 Final Estimated Population, Weldon Cooper Center for Public Service.

Note: Excludes HRMC and VCBR

Mental Retardation Training Center Bed Utilization by CSB and Region FY 2007
Beds Per 100,000 Population



State Training Center Utilization by CSB and Region -- FY 2007

	CSB	All Bed Days FY 2007	CSB Population	FY 2007 Bed Days Per 100 K Population	FY 2007 Beds Per 100 K Population	Beds Used
I	Central Virginia	18,479	234,140	7,892	21.62	50.63
	Harrisonburg-Rockingham	3,469	115,126	3,013	8.26	9.50
	Northwestern	6,772	206,470	3,280	8.99	18.55
	Rappahannock Area	8,326	301.831	2,758	7.56	22.81
	Rappahannock-Rapidan	9,511	156,737	6,068	16.63	26.06
	Region Ten	14,454	216,153	6,687	18.32	39.60
	Rockbridge Area	1,095	39,598	2,765	7.58	3.00
	Valley	6,429	113,797	5,650	15.48	17.61
II	Alexandria	8,401	132,176	6,356	17.41	23.02
	Arlington	16,390	191,623	8,553	23.43	44.90
	Fairfax-Falls Church	53,755	1,042,781	5,155	14.12	147.27
	Loudoun County	386	262,726	147	0.40	1.06
	Prince William County	11,813	412,894	2,861	7.84	32.36
III	Cumberland Mountain	20,608	97,305	21,179	58.02	56.46
	Dickenson County	3,220	16,226	19,845	54.37	8.82
	Highlands	9,456	69,184	13,668	37.45	25.91
	Mount Rogers	17,479	119,014	14,687	40.24	47.89
	New River Valley	17,051	167,915	10,155	27.82	46.72
	Planning District 1	13,582	93,637	14,505	39.74	37.21
IV	Chesterfield	4,064	289,568	1,403	3.85	11.13
	Crossroads	6,479	99,585	6,506	17.82	17.75
	District 19	16,588	169,419	9,791	26.82	45.45
	Goochland-Powhatan	2,156	45,818	4,706	12.89	5.91
	Hanover County	3,681	95,476	3,855	10.56	10.08
	Henrico Area	14,492	306,041	4,735	12.97	39.70
	Richmond BHA	18,853	191,740	9,833	26.94	51.65
V	Chesapeake	9,295	214,145	4,341	11.89	25.47
	Colonial	5,279	145,150	3,637	9.96	14.46
	Eastern Shore	7,952	52,000	15,292	41.90	21.79
	Hampton-Newport News	29,282	326,502	8,968	24.57	80.22
	Middle Pen.-Northern Neck	10,596	137,316	7,717	21.14	29.03
	Norfolk	36,968	235,071	15,726	43.09	101.28
	Portsmouth	14,388	98,514	14,605	40.01	39.42
	Virginia Beach	18,270	433,470	4,215	11.55	50.05
	Western Tidewater	7,604	137,341	5,537	15.17	20.83
VI	Danville-Pittsylvania	18,195	106,907	17,019	46.63	49.85
	Piedmont	6,106	137,922	4,427	12.13	16.73
	Southside	10,908	86,625	12,592	34.50	29.88
VII	Alleghany Highlands	2,555	22,757	11,227	30.76	7.00
	Blue Ridge	21,587	243,626	8,861	24.28	59.14
Out of State/Unknown/Unassigned		1,120	0	0	0	3.07
	VIRGINIA STATEWIDE	507,094	7,564,326	6,703.76	18.37	1,389.30

Source: DMHMRSAS AVATAR and 2005 Final Estimated Population, Weldon Cooper Center for Public Service.

State Mental Health and Mental Retardation Facility Numbers of Admissions, Separations and Average Daily Census FY 1976 to FY 2007

	State Mental Health Facilities*			State Mental Retardation Training Centers**		
	Number of Admissions	Number of Separations	Average Daily Census	Number of Admissions	Number of Separations	Average Daily Census
FY 1976	10,319	10,943	5,967	250	639	4,293
FY 1977	10,051	10,895	5,489	418	618	3,893
FY 1978	10,641	11,083	5,218	277	404	3,790
FY 1979	10,756	10,926	5,112	299	416	3,701
FY 1980	10,513	11,345	4,835	296	428	3,576
FY 1981	10,680	11,513	4,486	252	399	3,467
FY 1982	10,212	10,616	4,165	205	301	3,391
FY 1983	10,030	10,273	3,798	162	232	3,309
FY 1984	9,853	10,163	3,576	194	322	3,189
FY 1985	9,456	9,768	3,279	197	314	3,069
FY 1986	8,942	9,077	3,110	172	280	2,970
FY 1987	8,919	8,900	3,004	165	238	2,892
FY 1988	9,549	9,637	3,047	143	224	2,828
FY 1989	9,591	9,605	3,072	146	231	2,761
FY 1990	9,249	9,293	2,956	110	181	2,676
FY 1991	9,323	9,519	2,904	107	162	2,626
FY 1992	9,057	9,245	2,775	116	215	2,548
FY 1993	8,560	8,651	2,588	94	192	2,481
FY 1994	9,187	9,317	2,482	106	193	2,375
FY 1995	8,550	8,774	2,348	87	216	2,249
FY 1996	7,468	7,529	2,222	87	223	2,132
FY 1997	7,195	7,257	2,118	77	210	1,987
FY 1998	7,431	7,522	2,089	78	170	1,890
FY 1999	6,210	6,449	1,914	106	188	1,812
FY 2000	5,069	5,233	1,694	101	194	1,749
FY 2001	5,223	5,176	1,641	101	156	1,680
FY 2002	5,936	5,915	1,654	122	177	1,618
FY 2003	5,946	6,008	1,609	95	132	1,581
FY 2004	5,382	5,599	1,588	73	114	1,568
FY 2005	5,232	5,236	1,478	114	174	1,524
FY 2006	5,334	5,293	1,490	112	188	1,451
FY 2007	5,146	5.149	1,511	128	182	1,389

* Excludes Hiram Davis Medical Center and the Virginia Center for Behavioral Rehabilitation. Includes the Virginia Treatment Center for Children (VTCC) through FY 91 when the VTCC was transferred to MCV.

** Operations at SVTC began in 1971, NVTC began in 1973, SWVTC in 1973, and SEVTC began in 1975.

Appendix D
Prevalence Estimates by CSB

Estimated Prevalence of Serious Mental Illness by CSB and Region

	CSB	Population Age18+ (2005 Estimate)	Est. Population with SMI (5.4 %)	Lower Limit of SMI Estimate (3.7 %)	Upper Limit of SMI Estimate (7.1 %)
I	Central Virginia	181,984	9,827	6,733	12,921
	Harrisonburg-Rockingham	90,083	4,864	3,333	6,396
	Northwestern	154,251	8,330	5,707	10,952
	Rappahannock Area	210,450	11,364	7,787	14,942
	Rappahannock-Rapidan	115,071	6,214	4,258	8,170
	Region Ten	167,818	9,062	6,209	11,915
	Rockbridge Area	32,227	1,740	1,192	2,288
	Valley	88,920	4,802	3,290	6,313
II	Alexandria	110,288	5,956	4,081	7,830
	Arlington	162,049	8,751	5,996	11,505
	Fairfax-Falls Church	787,950	42,549	29,154	55,944
	Loudoun County	177,443	9,582	6,565	12,598
	Prince William County	282,978	15,281	10,470	20,091
III	Cumberland Mountain	78,355	4,231	2,899	5,563
	Dickenson County	13,149	710	487	934
	Highlands	55,452	2,994	2,052	3,937
	Mount Rogers	94,987	5,129	3,515	6,744
	New River Valley	137,844	7,444	5,100	9,787
	Planning District 1	74,624	4,030	2,761	5,298
IV	Chesterfield	207,719	11,217	7,686	14,748
	Crossroads	78,230	4,224	2,895	5,554
	District 19	130,237	7,033	4,819	9,247
	Goochland-Powhatan	35,093	1,895	1,298	2,492
	Hanover County	69,888	3,774	2,586	4,962
	Henrico Area	227,154	12,266	8,405	16,128
	Richmond BHA	148,801	8,035	5,506	10,565
V	Chesapeake	151,878	8,201	5,619	10,783
	Colonial	109,337	5,904	4,045	7,763
	Eastern Shore	40,240	2,173	1,489	2,857
	Hampton-Newport News	241,648	13,049	8,941	17,157
	Middle Peninsula-Northern Neck	107,692	5,815	3,985	7,646
	Norfolk	178,221	9,624	6,594	12,654
	Portsmouth	72,761	3,929	2,692	5,166
	Virginia Beach	319,875	17,273	11,835	22,711
	Western Tidewater	100,333	5,418	3,712	7,124
VI	Danville-Pittsylvania	83,306	4,499	3,082	5,915
	Piedmont	109,249	5,899	4,042	7,757
	Southside	68,831	3,717	2,547	4,887
VII	Alleghany Highlands	18,005	972	666	1,278
	Blue Ridge	189,964	10,258	7,029	13,487
	TOTAL	5,704,385	308,037	211,062	405,011

Population estimate is 2005 Estimates from Weldon Cooper Center for Public Service at the University of Virginia.
Population cohort age 18 and over is 75.37% of the total population.

Estimated Prevalence of Child/Adolescent Serious Emotional Disturbance by CSB and Region

	CSB	Population Age 9 through 17 (2005 Estimate)	Est. SED, Level of Functioning Score = 50		Est. SED, Level of Functioning Score = 60	
			Lower	Upper	Lower	Upper
I	Central Virginia	27,955	1,398	1,957	2,516	3,075
	Harrisonburg-Rockingham	12,430	622	870	1,119	1,367
	Northwestern	26,538	1,327	1,858	2,388	2,919
	Rappahannock Area	46,664	2,333	3,266	4,200	5,133
	Rappahannock-Rapidan	20,931	1,047	1,465	1,884	2,302
	Region Ten	24,785	1,239	1,735	2,231	2,726
	Rockbridge Area	4,192	210	293	377	461
	Valley	13,442	672	941	1,210	1,479
II	Alexandria	8,475	424	593	763	932
	Arlington	12,944	647	906	1,165	1,424
	Fairfax-Falls Church	130,996	6,550	9,170	11,790	14,410
	Loudoun County	34,687	1,734	2,428	3,122	3,816
	Prince William County	59,833	2,992	4,188	5,385	6,582
III	Cumberland Mountain	10,597	530	742	954	1,166
	Dickenson County	1,815	91	127	163	200
	Highlands	7,327	366	513	659	806
	Mount Rogers	13,340	667	934	1,201	1,467
	New River Valley	15,898	795	1,113	1,431	1,749
	Planning District 1	10,351	518	725	932	1,139
IV	Chesterfield	43,109	2,155	3,018	3,880	4,742
	Crossroads	11,756	588	823	1,058	1,293
	District 19	20,978	1,049	1,468	1,888	2,308
	Goochland-Powhatan	5,481	274	384	493	603
	Hanover County	13,909	695	974	1,252	1,530
	Henrico Area	40,961	2,048	2,867	3,686	4,506
	Richmond BHA	20,006	1,000	1,400	1,801	2,201
V	Chesapeake	34,071	1,704	2,385	3,066	3,748
	Colonial	19,907	995	1,393	1,792	2,190
	Eastern Shore	6,250	313	438	563	688
	Hampton-Newport News	41,767	2,088	2,924	3,759	4,594
	Middle Peninsula-Northern Neck	16,486	824	1,154	1,484	1,813
	Norfolk	24,823	1,241	1,738	2,234	2,731
	Portsmouth	12,706	635	889	1,144	1,398
	Virginia Beach	58,510	2,926	4,096	5,266	6,436
	Western Tidewater	19,159	958	1,341	1,724	2,107
VI	Danville-Pittsylvania	13,002	650	910	1,170	1,430
	Piedmont	16,000	800	1,120	1,440	1,760
	Southside	9,897	495	693	891	1,089
VII	Alleghany Highlands	2,506	125	175	226	276
	Blue Ridge	29,100	1,455	2,037	2,619	3,201
	TOTAL	943,584	47,179	66,051	84,923	103,794

Population estimate is 2005 Estimates from Weldon Cooper Center for Public Service at the University of Virginia**.**
Population cohort age 9 through 17 is 12.46% of the total population.
LOF = 50: lower 5%, upper 7%; LOF = 60: lower 9%, upper 11%.

Estimated Prevalence Mental Retardation by CSB and Region

	CSB	Population Age 0 through 5 (2005 Estimate)	Estimated # Infants/Toddlers with DD (Age 0 through 5)	Population Age 6+ (2005 Estimate)	Estimated # With MR (Age 6+) 1 %
I	Central Virginia	16,411	492	218,489	2,185
	Harrisonburg-Rockingham	8,490	255	106,610	1,066
	Northwestern	15,568	467	188,832	1,888
	Rappahannock Area	25,424	763	271,376	2,714
	Rappahannock-Rapidan	11,328	340	142,572	1,426
	Region Ten	15,591	468	200,209	2,002
	Rockbridge Area	2,302	69	37,598	376
	Valley	7,962	239	106,438	1,064
II	Alexandria	13,291	399	121,909	1,219
	Arlington	15,825	475	179,775	1,798
	Fairfax-Falls Church	93,434	2,803	962,166	9,622
	Loudoun County	26,388	792	225,912	2,259
	Prince William County	41,463	1,244	363,637	3,636
III	Cumberland Mountain	6,279	188	92,221	922
	Dickenson County	997	30	15,503	155
	Highlands	4,448	133	65,052	651
	Mount Rogers	7,919	238	112,381	1,124
	New River Valley	10,308	309	158,792	1,588
	Planning District 1	6,311	189	88,189	882
IV	Chesterfield	22,393	672	264,107	2,641
	Crossroads	6,494	195	93,306	933
	District 19	13,008	390	157,492	1,575
	Goochland-Powhatan	2,909	87	42,191	422
	Hanover County	7,049	211	88,051	881
	Henrico Area	24,847	745	280,953	2,810
	Richmond BHA	18,093	543	175,207	1,752
V	Chesapeake	17,903	537	195,497	1,955
	Colonial	8,914	267	135,086	1,351
	Eastern Shore	3,894	117	48,406	484
	Hampton-Newport News	30,971	929	296,729	2,967
	Middle Peninsula-Northern Neck	8,816	264	128,684	1,287
	Norfolk	23,834	715	211,666	2,117
	Portsmouth	9,509	285	89,295	893
	Virginia Beach	39,183	1,175	396,417	3,964
	Western Tidewater	10,697	321	124,903	1,249
VI	Danville-Pittsylvania	7,922	238	100,278	1,003
	Piedmont	9,359	281	129,941	1,299
	Southside	5,977	179	81,723	817
VII	Alleghany Highlands	1,590	48	21,410	214
	Blue Ridge	17,619	529	227,981	2,280
	TOTAL	620,720	18,622	6,946,984	69,470

Population estimate is 2005 Estimates from Weldon Cooper Center for Public Service at the University of Virginia.
Population cohort age 0 through 5 is 8.2% of the total population.
Population cohort age 6+ is 91.79% of the total population.

Estimated Prevalence of Drug and Alcohol Dependence by CSB and Region

	CSB	Population 12+ (2005 Estimate)	Estimated Drug Dependence 1.89 %	Estimated Alcohol Dependence 3.31 %	Total Estimated # Drug & Alcohol Dependence*
I	Central Virginia	200,875	3,797	6,649	10,446
	Harrisonburg-Rockingham	98,335	1,859	3,255	5,113
	Northwestern	172,015	3,251	5,694	8,945
	Rappahannock Area	241,969	4,573	8,009	12,582
	Rappahannock-Rapidan	129,173	2,441	4,276	6,717
	Region Ten	184,410	3,485	6,104	9,589
	Rockbridge Area	35,100	663	1,162	1,825
	Valley	98,033	1,853	3,245	5,098
II	Alexandria	115,797	2,189	3,833	6,021
	Arlington	170,454	3,222	5,642	8,864
	Fairfax-Falls Church	875,579	16,548	28,982	45,530
	Loudoun County	199,658	3,774	6,609	10,382
	Prince William County	322,230	6,090	10,666	16,756
III	Cumberland Mountain	85,461	1,615	2,829	4,444
	Dickenson County	14,395	272	476	749
	Highlands	60,379	1,141	1,999	3,140
	Mount Rogers	103,926	1,964	3,440	5,404
	New River Valley	148,608	2,809	4,919	7,728
	Planning District 1	81,630	1,543	2,702	4,245
IV	Chesterfield	236,733	4,474	7,836	12,310
	Crossroads	86,221	1,630	2,854	4,483
	District 19	144,349	2,728	4,778	7,506
	Goochland-Powhatan	38,761	733	1,283	2,016
	Hanover County	79,221	1,497	2,622	4,119
	Henrico Area	254,692	4,814	8,430	13,244
	Richmond BHA	161,997	3,062	5,362	8,424
V	Chesapeake	175,171	3,311	5,798	9,109
	Colonial	122,856	2,322	4,067	6,389
	Eastern Shore	44,484	841	1,472	2,313
	Hampton-Newport News	269,135	5,087	8,908	13,995
	Middle Peninsula-Northern Neck	119,039	2,250	3,940	6,190
	Norfolk	194,079	3,668	6,424	10,092
	Portsmouth	81,269	1,536	2,690	4,226
	Virginia Beach	359,390	6,792	11,896	18,688
	Western Tidewater	113,307	2,142	3,750	5,892
VI	Danville-Pittsylvania	92,138	1,741	3,050	4,791
	Piedmont	120,123	2,270	3,976	6,246
	Southside	75,474	1,426	2,498	3,925
VII	Alleghany Highlands	19,651	371	650	1,022
	Blue Ridge	209,561	3,961	6,936	10,897
	TOTAL	6,335,678	119,744	209,711	329,455

Population estimate is 2005 Estimates from Weldon Cooper Center for Public Service at the University of Virginia.
*Note: Total includes a duplicated count of persons with co-occurring drug and alcohol dependence.
Population cohort age 12 and over is 83.7% of the total population.

Appendix E
Individuals on Waiting Lists for CSB Services by CSB

Adults on CSB Mental Health Services Waiting Lists -- January - April 2007

	CSB	Adult SMI Prevalence	Unduplicated # Served (FY2006 4th Quarter Rept.)		On CSB Waiting Lists		Total on CSB Waiting List
			# Served	# SMI	Receiving CSB Services	Not Receiving Some CSB Services	
I	Central Virginia	9,827	3,105	1,361	149	11	160
	Harrisonburg-Rockingham	4,864	1,359	766	150	4	154
	Northwestern	8,330	2,231	1,297	93	7	100
	Rappahannock Area	11,364	2,907	1,584	39	1	40
	Rappahannock-Rapidan	6,214	2,206	636	89	0	89
	Region Ten	9,062	1,862	1,316	48	25	73
	Rockbridge	1,740	874	418	0	30	30
	Valley	4,802	1,767	657	167	42	209
II	Alexandria	5,956	1,919	524	26	6	32
	Arlington	8,751	2,206	1,509	45	1	46
	Fairfax-Falls Church	42,549	8,978	8,087	348	5	353
	Loudoun	9,582	2,050	655	26	21	47
	Prince William	15,281	2,346	403	123	52	175
III	Cumberland Mountain	4,231	1,488	1,097	121	2	123
	Dickenson County	710	533	462	0	0	0
	Highlands	2,994	2,211	794	17	0	17
	Mount Rogers	5,129	2,770	2,287	827	1	828
	New River Valley	7,444	2,367	1,263	16	0	16
	P.D. 1	4,030	2,923	2,355	54	0	54
IV	Chesterfield	11,217	2,003	1,076	156	34	190
	Crossroads	4,224	1,874	842	28	35	63
	District 19	7,033	2,380	1,369	17	17	34
	Goochland-Powhatan	1,895	346	138	1	0	1
	Hanover	3,774	1,793	365	63	0	63
	Henrico	12,266	3,468	1,719	221	0	221
	Richmond BHA	8,035	754	1,940	66	7	73
V	Chesapeake	8,201	1,748	668	101	3	104
	Colonial	5,904	1,663	557	56	6	62
	Eastern Shore	2,173	769	338	0	0	0
	Hampton-Newport News	13,049	5,571	2,889	0	0	0
	Middle Pen.-Northern Neck	5,815	2,176	862	52	105	157
	Norfolk	9,624	2,372	1,625	0	0	0
	Portsmouth	3,929	1,332	953	2	4	6
	Virginia Beach	17,273	2,820	2,461	138	33	171
	Western Tidewater	5,418	1,207	789	65	16	81
VI	Danville-Pittsylvania	4,499	1,829	785	27	38	65
	Piedmont	5,899	2,561	2,002	9	77	86
	Southside	3,717	1,328	716	4	3	7
VII	Alleghany Highlands	972	647	339	0	0	0
	Blue Ridge	10,258	3,374	2,895	74	25	99
	TOTAL	308,037	88,117	52,799	3,418	611	4,029

Children and Adolescents on CSB Mental Health Services Waiting Lists – January - April 2007

	CSB	SED Prevalence (LOF = 50 Upper Range)	Unduplicated # Served (FY 2006 4th Quarter Report.) # Served	# SED	On CSB Waiting Lists Receiving CSB Services	Not Receiving Some CSB Services	Total on CSB Waiting List
	Central Virginia	1,957	2,079	717	73	37	110
	Harrisonburg-Rockingham	870	420	260	35	0	35
	Northwestern	1,858	752	503	3	12	15
	Rappahannock Area	3,266	899	654	43	1	44
	Rappahannock-Rapidan	1,465	621	335	12	0	12
	Region Ten	1,735	800	425	21	7	28
	Rockbridge	293	274	175	1	26	27
	Valley	941	481	219	10	9	19
II	Alexandria	593	346	113	1	0	1
	Arlington	906	107	254	15	32	47
	Fairfax-Falls Church	9,170	2,135	1393	24	22	46
	Loudoun	2,428	679	351	9	3	12
	Prince William	4,188	676	128	2	10	12
III	Cumberland Mountain	742	579	545	304	1	305
	Dickenson County	127	143	116	0	0	0
	Highlands	513	606	429	49	3	52
	Mount Rogers	934	750	519	186	0	186
	New River Valley	1,113	844	733	0	0	0
	P.D. 1	725	1,175	825	26	0	26
IV	Chesterfield	3,018	456	Not Available	68	37	105
	Crossroads	823	619	303	26	22	48
	District 19	1,468	680	308	1	0	1
	Goochland-Powhatan	384	101	53	0	0	0
	Hanover	974	658	411	22	0	22
	Henrico	2,867	1,078	504	40	35	75
	Richmond BHA	1,400	4,777	984	10	9	19
V	Chesapeake	2,385	246	88	3	0	3
	Colonial	1,393	316	92	43	8	51
	Eastern Shore	438	304	209	0	0	0
	Hampton-Newport News	2,924	2,195	2314	0	0	0
	Middle Pen.-Northern Neck	1,154	823	481	43	70	113
	Norfolk	1,738	343	167	0	0	0
	Portsmouth	889	175	215	0	0	0
	Virginia Beach	4,096	504	565	30	5	35
	Western Tidewater	1,341	394	221	40	1	41
VI	Danville-Pittsylvania	910	273	153	9	35	44
	Piedmont	1,120	864	1004	31	7	38
	Southside	693	278	159	0	0	0
VII	Alleghany Highlands	175	210	97	0	0	0
	Blue Ridge	2,037	955	670	44	64	108
	TOTAL	66,051	30,615	17692	1,224	456	1,680

Individuals on CSB Mental Retardation Services Waiting Lists – January - April 2007

	CSB	MR Prevalence Age 6 and Over	Infant & Toddler DD Prevalence Age 0 thru 5	Unduplicated # Served (FY 2006 4th Quarter Report)	On CSB Waiting Lists Receiving CSB Services	Not Receiving Some CSB Services	Total on CSB Waiting List
I	Central Virginia	2,185	492	938	106	0	106
	Harrisonburg-Rockingham	1,066	255	448	104	13	117
	Northwestern	1,888	467	625	149	11	160
	Rappahannock Area	2,714	763	1,029	187	45	232
	Rappahannock-Rapidan	1,426	340	492	72	0	72
	Region Ten	2,002	468	465	112	50	162
	Rockbridge	376	69	278	26	4	30
	Valley	1,064	239	509	71	27	98
II	Alexandria	1,219	399	520	2	1	3
	Arlington	1,798	475	297	87	59	146
	Fairfax-Falls Church	9,622	2,803	3,604	434	326	760
	Loudoun	2,259	792	777	84	78	162
	Prince William	3,636	1,244	1,301	122	65	187
III	Cumberland Mountain	922	188	511	69	1	70
	Dickenson County	155	30	37	2	0	2
	Highlands	651	133	304	2	0	2
	Mount Rogers	1,124	238	634	178	5	183
	New River Valley	1,588	309	415	35	39	74
	P.D. 1	882	189	377	8	5	13
IV	Chesterfield	2,641	672	1,354	1,024	10	1,034
	Crossroads	933	195	216	21	27	48
	District 19	1,575	390	571	71	2	73
	Goochland-Powhatan	422	87	173	15	15	30
	Hanover	881	211	464	130	7	137
	Henrico	2,810	745	1,361	249	0	249
	Richmond BHA	1,752	543	1,164	169	2	171
V	Chesapeake	1,955	537	804	119	32	151
	Colonial	1,351	267	400	40	1	41
	Eastern Shore	484	117	301	7	3	10
	Hampton-Newport News	2,967	929	609	314	0	314
	Middle Pen.-Northern Neck	1,287	264	564	53	18	71
	Norfolk	2,117	715	912	27	30	57
	Portsmouth	893	285	434	103	30	133
	Virginia Beach	3,964	1,175	1,235	185	62	247
	Western Tidewater	1,249	321	618	114	30	144
VI	Danville-Pittsylvania	1,003	238	415	68	10	78
	Piedmont	1,299	281	463	56	29	85
	Southside	817	179	251	17	4	21
VII	Alleghany Highlands	214	48	204	14	5	19
	Blue Ridge	2,280	529	819	206	68	274
	TOTAL	69,470	18,622	26,893	4,852	1,114	5,966

Adults and Adolescents on CSB Substance Abuse Services Waiting Lists – January - April 2007

	CSB	Drug & Alcohol Dependence Prevalence	Unduplicated # Served (FY 2006 4th Qtr. Rept.)	On CSB Waiting Lists				Totals on CSB Adult and Adolescent Waiting Lists		
				Receiving CSB Services		Not Receiving Some CSB Services				
				Adult	Adol.	Adult	Adol.	Adult	Adol.	Total
I	Central Virginia	10,446	1,759							
	Harrisonburg-Rockingham	5,113	2,947							
	Northwestern	8,945	1,123	46	0	7	0	53	0	53
	Rappahannock Area	12,582	2,318	27	5	1	0	28	5	33
	Rappahannock-Rapidan	6,717	961	11	0	2	0	13	0	13
	Region Ten	9,589	1,477	2	3	0	1	2	4	6
	Rockbridge	1,825	352	0	0	8	2	8	2	10
	Valley	5,098	1,292	8	0	22	9	30	9	39
II	Alexandria	6,021	1,494	3	0	3	0	6	0	6
	Arlington	8,864	1,162	0	10	0	5	0	15	15
	Fairfax-Falls Church	45,530	5,628	465	76	97	35	562	111	673
	Loudoun	10,382	1,791	47	7	6	0	53	7	60
	Prince William	16,756	1,974	12	0	44	0	56	0	56
III	Cumberland Mountain	4,444	1,465	229	4	10	0	239	4	243
	Dickenson County	749	211	5	0	10	1	15	1	16
	Highlands	3,140	975	1	0	1	0	1	0	1
	Mount Rogers	5,404	826	41	2	0	0	41	2	43
	New River Valley	7,728	1,659	0	0	0	0	0	0	0
	P.D. 1	4,245	1,272	93	0	2	0	95	0	95
IV	Chesterfield	12,310	1,374	184	13	37	1	221	14	235
	Crossroads	4,483	658	0	0	15	0	15	0	15
	District 19	7,506	1,181	0	0	2	0	2	0	2
	Goochland-Powhatan	2,016	180	0	0	0	0	0	0	0
	Hanover	4,119	537	0	0	0	0	0	0	0
	Henrico	13,244	2,694	23	3	4	3	27	6	33
	Richmond Behavioral	8,424	2,215	20	4	20	9	40	13	53
V	Chesapeake	9,109	1,320	39	4	3	11	42	15	57
	Colonial	6,389	1,055	73	0	3	0	76	0	76
	Eastern Shore	2,313	269	0	0	0	0	0	0	0
	Hampton-Newport News	13,995	1,704	0	0	0	0	0	0	0
	Middle Pen.-Northern Neck	6,190	1,428	29	0	15	0	44	0	44
	Norfolk	10,092	2,514	0	0	0	0	0	0	0
	Portsmouth	4,226	897	1	0	1	0	2	0	2
	Virginia Beach	18,688	1,053	0	0	179	0	179	0	179
	Western Tidewater	5,892	636	90	0	15	0	105	0	105
VI	Danville-Pittsylvania	4,791	1,240	44	4	33	8	77	12	89
	Piedmont	6,246	859	10	2	30	4	40	6	46
	Southside	3,925	327	0	0	0	0	0	0	0
VII	Alleghany Highlands	1,022	298	0	0	0	0	0	0	0
	Blue Ridge	10,897	1,518	30	7	34	1	64	8	72
	TOTAL	329,455	54,643	1,565	144	616	90	2,181	234	2,415

Appendix F
Proposed State Facility Capital Priority Listing 2008 – 2014

	Project Title	Estimated Cost
2008-10	Maintenance Reserve	$6,075,000
	Roof Replacement-Phase 2	18,280,000
	Life Safety Code Renovations, Phase 1	10,773,000
	Repair/Replace Campus Infrastructure, Phase 1	4,134,000
	Repair/Replace Boilers, Heat Distribution and HVAC systems, Phase 4	15,273,000
	Abate Environmental Hazards, Phase 1	4,224,000
	Repair/Replace Southeastern Virginia Training Center	33,987,000
	Community Housing for Southeastern Virginia Training Center	23,607,000
	Planning: Locating New Facility for Sexually Violent Predators	2,603,000
	Repair/Replace Central Virginia Training Center	43,887,000
	Community Housing for Central Virginia Training Center	49,707,000
	Replace Western State Hospital	122,203,000
	Replacement Support Service Facility, Eastern State Hospital	31,911,815
	Planning for the Replacement of the Forensic Unit at Central State Hospital	2,641,000
	Building Demolition, Phase 1	2,588,000
	2008-2010 Subtotal	**$371,893,815**
2010-12	Roof Replacement, Phase 3	$12,716,000
	Life Safety Code Renovations, Phase 2	7,562,000
	Boilers, Heat Distribution and HVAC systems, Phase 5	21,772,000
	Food Service Renovations	5,605,100
	Renovations to Create Treatment Mall at SWVMHI	7,083,000
	Renovations and Additions to Northern Virginia Training Center	228,031,995
	Abate Environmental Hazards	2,694,000
	Construct Replacement Forensic Unit, Central State Hospital	86,701,000
	Planning for Replacement of Adult Civil Units - Central State Hospital	7,571,000
	Construct Client Services/Activity Center, Southside Virginia Training Center	44,452,000
	Construct New Facility for the Treatment of Sexually Violent Predators	118,906,000
	Repair/Replace Campus Infrastructures, Phase 2	5,993,000
	Construct Administration and Parking Buildings at Northern Virginia Training Center	22,749,000
	Building Demolition, Phase 2	3,010,000
	2010-2012 Subtotal	**$574,846,095**
2012-14	Roof Replacement, Phase 3	$7,514,000
	Repair/Replace Boiler, Heat Distribution and HVAC Systems, Phase 6	17,506,000
	Construct Replacement for Adult Civil Units, Central State Hospital	133,066,000
	Renovate Hiram W. Davis Medical Center	8,901,000
	Abate Environmental Hazards, Phase 3	2,654,000
	Renovations and Additions to Southwestern Virginia Training Center	38,990,000
	Renovate Main Hospital, Piedmont Geriatric Hospital	40,578,000
	Renovate Main Hospital, Southern Virginia Mental Health Institute	11,609,000
	Renovate Main Hospital building, Catawba Hospital	24,834,000
	Repair/Replace Campus Infrastructures, Phase 3	3,151,000
	Building Demolition, Phase 3	2,035,000
	2012-2014 Subtotal	**$290,838,000**
	Six Year Total	**$1,237,577,910**

Appendix G
Glossary of Department of Mental Health, Mental Retardation, and Substance Abuse Services and Services System Terms and Acronyms

Acronym/Term	Name
AA	Alcoholics Anonymous
AAIDD	American Association on Intellectual and Developmental Disabilities
ABS	Adaptive Behavior Scale (MR)
ACT	Assertive Community Treatment
AD	Americans with Disabilities Act (U.S.)
ADA	Assistant Director Administrative (DMHMRSAS state facility position)
ADC	Average Daily Census
ADRDA	Alzheimer's Disease and Related Disorders Association
ADSCAP	AIDS Control and Prevention Project
AHCPR	Agency for Health Care Policy and Research
AHP	Advocates for Human Potential
AITR	Agency Information Technology Resource
ALF	Assisted Living Facility (formerly Adult Care Residence)
ALOS	Average Length of Stay
AMA	Against Medical Advice
AOD	Alcohol and Other Drugs
AODA	Alcohol and Other Drug Abuse
APA	Administrative Process Act (Virginia)
APA	American Psychiatric Association
APA	American Psychological Association
AR	Authorized Representative
Arc of Virginia	Association for Retarded Citizens of Virginia
ARR	Annual Resident Review
ASAM	American Society of Addiction Medicine
ASFA	Adoption and Safe Families Act of 1997 (U.S.)
ASI	Addiction Severity Index
AT	Assistive Technology
ATOD	Alcohol, Tobacco and Other Drugs
ATTC	Addiction Technology Transfer Center
AVATAR	State Facility Information Patient/Billing System (DMHMRSAS information system)
AWOP	Absent Without Permission
BHA	Behavioral Health Authority
C&A	Child and Adolescent
CAFAS	Child and Adolescent Functional Assessment Scale
CAPTA	Child Abuse Prevention Treatment Act
CARF	Commission on Accreditation of Rehabilitation Facilities
CARS	Community Automated Reporting System (DMHMRSAS)
CASA	National Center on Addiction and Substance Abuse at Columbia University
CASSP	Child and Adolescent Service Systems Program
CBT	Cognitive Behavioral Therapy
CCCA	Commonwealth Center for Children and Adolescents (state hospital located in Staunton)
CCISC	Comprehensive, Continuous, Integrated System of Care
CCS	Community Consumer Submission (community information extract application)
CDS	College of Direct Support
CELT	Consumer Education and Leadership Training
CFBHPPC	Child and Family Behavioral Health Policy and Planning Committee

CH	Catawba Hospital (state hospital located near Salem)
CHAP	Child Health Assistance Program
CHRIS	Comprehensive Human Rights Information System (DMHMRSAS human rights application))
CLAS	Culturally and Linguistically Appropriate Services (standards)
CM	Case Management
CMHS	Center for Mental Health Services (U.S.)
CMS	Centers for Medicare and Medicaid Services (U.S.)
CO	Central office (DMHMRSAS)
Coalition	Coalition for Virginians with Mental Disabilities
COBRA	Comprehensive Omnibus Budget Reconciliation Act (also OBRA)
CODIE	Central office Data and Information Exchange (DMHMRSAS intranet)
COPN	Certificate of Public Need
COSIG	Co-Occurring State Incentive Grant
COY	Commission on Youth (Virginia)
COV	Commonwealth of Virginia
CPI	Consumer Price Index
CPP	Certified Prevention Professional
CPMT	Community Policy and Management Team
CRC	Commitment Review Committee
CRF	Classification Rating Form (MH-Adult)
CRIPA	Civil Rights of Institutionalized Persons Act (U.S.)
CSA	Comprehensive Services Act for Troubled Children and Youth (Virginia)
CSAO	Consortium of Substance Abuse Organizations (Virginia)
CSAP	Center for Substance Abuse Prevention (U.S.)
CSAT	Center for Substance Abuse Treatment (U.S.)
CSB	Community Services Board
CSH	Central State Hospital (DMHMRSAS facility located in Dinwiddie)
CSP	Community Support Program
CSQMC	Clinical Services Quality Management Committee (DMHMRSAS)
CSS	Community Support System
CVTC	Central Virginia Training Center (DMHMRSAS facility located near Lynchburg)
DAD Project	Discharge Assistance and Diversion Project (Northern Virginia)
DAP	Discharge Assistance Project
DARC	Division of Administration and Regulatory Compliance (DMHMRSAS central office)
DBSA	Depression and Bipolar Support Alliance
DCS	Division of Community Services (DMHMRSAS central office)
DCHVP	Domiciliary Care for the Homeless Veterans Program
DCJS	Department of Criminal Justice Services (Virginia)
DD	Developmentally Disabled or Developmental Disabilities
DDHH	Department for the Deaf and Hard of Hearing (Virginia)
DFA	Division of Financial Administration (DMHMRSAS central office)
DFM	Division of Facility Management (DMHMRSAS central office)
DHCD	Department of Housing and Community Development (Virginia)
DHHS	Department of Health and Human Services (U.S.) (or HHS)
DHQC	Division of Health and Quality Care (DMHMRSAS central office)
DI	Departmental Instruction (DMHMRSAS internal policies and procedures)
DJJ	Department of Juvenile Justice
DMAS	Department of Medical Assistance Services (Virginia)
DMC	Data Management Committee of the VACSB
DMHMRSAS	Department of Mental Health, Mental Retardation and Substance Abuse Services (the Department) (Virginia)
DOC	Department of Corrections (Virginia)

DOD	Department of Defense (U.S.)
DOE	Department of Education (Virginia)
DOJ	Department of Justice (U.S.)
DPB	Department of Planning and Budget (Virginia)
DPTF	Data Policy Task Force (DMHRMSAS)
DPSP	Division of Programs for Special Populations (U.S.)
DRGs	Diagnosis-Related Groups
DRS	Department of Rehabilitative Services (Virginia)
DSM-IV	Diagnostic and Statistical Manual (Mental Disorders), Fourth Edition
DVH	Department for the Visually Handicapped (Virginia)
DVS	Department of Veterans Services (Virginia)
EBP	Evidence-Based Practice
ECA	Epidemiologic Catchment Area
ECO	Emergency Custody Order
ED Forum	Executive Directors Forum of the VACSB
EHR	Electronic Health Record
EI	Early Intervention
EIA	Early Intervention Assistance
EMTALA	Emergency Medical Treatment and Active Labor Act
EO	Executive Order
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
ER	Emergency Room
ESH	Eastern State Hospital (state hospital located in Williamsburg)
FAPT	Family Assessment and Planning Team
FAS	Fetal Alcohol Syndrome
FFP	Federal Financial Participation (Medicaid)
FFS	Fee-for-Service
FFY	Federal Fiscal Year
FHA	Federal Housing Administration (U.S.)
FMLA	Family and Medical Leave Act
FMR	Fair Market Rent (U.S. Housing and Urban Development)
FMS	Financial Management System (DMHMRSAS financial information system)
FRP	Forensic Review Panel (DMHMRSAS)
FTE	Full Time Equivalent
FY	Fiscal Year (State)
GA	General Assembly (Virginia)
GAF	Global Assessment of Functioning
GOSAP	Home and Community-Based (Medicaid MR Waiver)
HGTC	Hancock Geriatric Treatment Center (at Eastern State Hospital in Williamsburg)
HHR	Health and Human Resources Secretariat (Virginia)
HIE	Homeless Information Exchange
HIPAA	Health Insurance Portability and Accountability Act of 1996
HJR	House Joint Resolution (also HJ)
HMO	Health Maintenance Organization
HPO	High Performance Organization
HPR	Health Planning Region
HPSA	Health Professional Shortage Area
HRDM	Human Resources Development and Management Office (in DMHMRSAS central office)
HRIS	Human Resources Information System (DMHMRSAS)
HRSA	Health Resources and Services Administration (U.S.)
HSA	Health Services Area
HUD	Housing and Urban Development (U.S.)

HVAC	Heating, Ventilation, and Air Conditioning
HWDMC	Hiram W. Davis Medical Center (DMHMRSAS medical center located in Dinwiddie)
I&R	Information and Referral
IAPSRS	International Association of Psychosocial Rehabilitation Services
ICD	International Classification of Diseases
ICF/MR	Intermediate Care Facility for the Mentally Retarded
ICT	Intensive Community Treatment
ID	Intellectual Disability
IDDT	Integrated Dual Disorders Treatment
IDEA	Individuals with Disabilities Education Act (U.S.)
ILPPP	University of Virginia Institute of Law, Psychiatry and Public Policy
IMD	Institution for the Mentally Disabled (CMS term)
IM&R	Illness Management and Recovery
ISP	Individualized Services Plan
ISP	Integrated Strategic Plan (DMHMRSAS)
IP	Inpatient
IPA	Independent Practice Association
IQ	Intelligence Quotient
IS	Information Systems
ISP	Integrated Strategic Plan (DMHMRSAS strategic plan)
ISN	Integrated Service Network
IT	Information Technology
JAIBC	Juvenile Accountability Incentive Block Grant (federal block grant)
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JCHC	Joint Commission on Health Care
JJDPA	Juvenile Justice Delinquency Prevention Act (U.S.)
JLARC	Joint Legislative Audit and Review Commission
LEAP	Leadership-Empowerment-Advocacy Program
LEP	Limited English Proficiency
LGD	Local Government Department (a type of CSB)
LHRC	Local Human Rights Committee
LICC	Local Interagency Coordinating Council (Part C)
LOF	Level of Functioning
LOS	Length of Stay
LSC	Life Safety Code
LTC	Long Term Care
MCH	Maternal and Child Health
MCO	Managed Care Organization
MDR	Multidrug-Resistant
Medicaid DSA	Medicaid Disproportionate Share Adjustments
Medicaid DSH	Medicaid Disproportionate Share Hospital
MedIs	Medication Information System
MESA	Mutual Education, Support, and Advocacy
MET	Motivational Enhancement Therapy
MH	Mental Health
MHT SIG	Mental Health Transformation State Incentive Grant
MHA-V	Mental Health America – Virginia (formerly Mental Health Association of Virginia)
MHI	Mental Health Institute
MHPC	Mental Health Planning Council
MHPRC	Mental Health Policy Resource Center
MHSIP	Mental Health Statistics Improvement Program
MHWG	Mental Health Work Group (of the Northern Virginia Regional Partnership)

MIC	Maternal and Infant Care
Mid-ATTC	Mid Atlantic Addiction Technology Transfer Center
MI/MR	Mental Illness/Mental Retardation (co-occurring diagnosis)
MI/SUD	Mental Illness/Substance Use Disorder (co-occurring diagnosis)
MMWR	Morbidity and Mortality Weekly Report
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
MR	Mental Retardation
MR/MI	Mental Retardation/Mental Illness (co-occurring diagnosis)
MR waiver	Medicaid Mental Retardation Home and Community-Based Waiver
MST	Multi-systemic Therapy
MUA	Medically Underserved Area
NA	Narcotics Anonymous
NADD	National Association for the Dually Diagnosed
NAEH	National Alliance to End Homelessness
NAFARE	National Association for Family Addiction, Research and Education
NAMI	National Alliance for the Mentally Ill
NAMI -VA	National Alliance for the Mentally Ill - Virginia
NAPH	National Association of Public Hospitals
NAPWA	National Association of People with AIDS
NASADAD	National Association of State Alcohol and Drug Abuse Directors
NASDDDS	National Association of Directors of Developmental Disabilities Services
NSDUH	National Household Survey on Drug Use and Health
NASMHPD	National Association of State Mental Health Program Directors
NASTAD	National Alliance of State and Territorial AIDS Directors
NCADD	National Council on Alcoholism and Drug Dependence
NCADI	National Clearinghouse for Alcohol and Drug Information
NCSACW	National Center for Substance Abuse and Child Welfare
NCCAN	National Center on Child Abuse and Neglect
NCH	National Coalition for the Homeless
NCS	National Comorbidity Survey
NCSACW	National Center for Substance Abuse and Child Welfare
NF	Nursing Facility
NGF	Non-general Funds
NGRI	Not Guilty by Reason of Insanity
NHCHC	National Health Care for the Homeless Council
NHIS-D	National Health Interview Survey Disability Supplement
NHSDA	National Household Survey on Drug Abuse
NIAAA	National Institute on Alcohol and Alcohol Abuse (U.S.)
NIDA	National Institute on Drug Abuse (U.S.)
NIH	National Institutes of Health (U.S.)
NIMH	National Institute on Mental Health (U.S.)
NOMS	National Outcomes Measures (SAMHSA)
NVMHCA	Northern Virginia Mental Health Consumers Association
NVMHI	Northern Virginia Mental Health Institute (state hospital located in Falls Church)
NVTC	Northern Virginia Training Center (state training center located in Fairfax)
OAE	Office of Architectural and Engineering Services (DMHMRSAS central office)
OAG	Office of the Attorney General (Virginia)
OAS	Office of Administrative Services (DMHMRSAS central office)
OB	Office of Budget and Financial Reporting (DMHMRSAS central office)
OBRA	Omnibus Budget Reconciliation Act of 1989 (U.S.)
OBS	Organic Brain Syndrome

OCAR	Office of Cost Accounting and Reimbursement (DMHMRSAS central office)
OCC	Office of Community Contracting (DMHMRSAS central office)
OFRC	Office of Financial Reporting and Compliance (DMHMRSAS central office)
OFS	Office of Forensic Services (DMHMRSAS central office)
OFS	Office of Financial and Grants Management (DMHMRSAS central office)
OHR	Office of Human Rights (DMHMRSAS central office)
OIA	Office of Internal Audit (DMHMRSAS central office)
OIG	Office of the Inspector General (Virginia)
OIM	Office of Investigations Management (DMHMRSAS central office)
OITS	Office of Information Technology Services (DMHMRSAS central office)
OL	Office of Licensing (DMHMRSAS central office)
OLIS	Office of Licensing Information System (DMHMRSAS licensing application)
OLPR	Office of Legislation and Public Relations (DMHMRSAS central office)
OMHRC	Office of Minority Health Resource Center (U.S.)
OMHS	Office of Mental Health Services (DMHMRSAS central office)
OMRS	Office of Mental Retardation Services (DMHMRSAS central office)
ONAP	Office of National AIDS Policy (U.S.)
OPD	Office of Planning and Development (DMHMRSAS central office)
OQI	Office of Quality Improvement (DMHMRSAS central office)
OQM	Office of Quality Management (DMHMRSAS central office)
OP	Outpatient
ORLA	Office of Risk and Liability Affairs (DMHMRSAS central office)
OSAS	Office of Substance Abuse Services (DMHMRSAS central office)
OSHY	Outreach Services for Homeless Youth
OT	Occupational Therapy
OUR	Office of Utilization Management (DMHMRSAS central office)
PACT	Program of Assertive Community Treatment
PAIMI	Protection and Advocacy for Individuals with Mental Illnesses Act (U.S.)
PAIR	Parents and Associates of the Institutionalized Retarded
Part C	Part C of the IDEA (Federal funds for early intervention services)
PASARR	Pre-Admission Screening/Annual Resident Review
PATH	Projects for Assistance in Transition from Homelessness (federal grant)
PBPS	Performance-Based Prevention System
PBS	Positive Behavioral Supports
PCP	Person Centered Planning
PEATC	Parent Educational Advocacy Training Center
PGH	Piedmont Geriatric Hospital (state hospital located in Burkeville)
PHA	Public Health Association
PHS	Public Health Service (U.S.)
PHWG	Private Hospital Work Group (of the Northern Virginia Regional Partnership)
PIP	Program Improvement Plan
PKI	Public Key Infrastructure
PL	Public Law (U.S.)
PMPM	Per Member Per Month
POIS	Purchase of Individualized Services
Pony Walls	Half-Height Walls in State Facility Patient Living Areas
POS	Purchase of Services
PPAC	Prevention and Promotion Advisory Council
PPC	Patient Placement Criteria
PPEA	Public Private Educational and Infrastructure Act of 2002 (Virginia)
PPO	Preferred Provider Organization
PPW	Pregnant and Postpartum Women

PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (U.S)
PRAIS	Patient Resident Automated Information System (DMHMRSAS application, now AVATAR))
PRC	Perinatal Resource Center
PSR	Psychosocial Rehabilitation
PT	Physical Therapy
PTSD	Post Traumatic Stress Disorder
PWA	Persons with AIDS
QA	Quality Assurance
QI	Quality Improvement
QMHP	Qualified Mental Health Professional
QMRP	Qualified Mental Retardation Professional
RCSC	Regional Community Support Centers
REACH	Recovery, Education and Creative Healing
Region I	Northwest Virginia
Region II	Northern Virginia
Region III	Far Southwestern Virginia
Region IV	Central Virginia
Region V	Eastern Virginia
Region VI	Southside Virginia
Region VII	Catawba Virginia
RM	Risk Management
SA	Substance Abuse
SAARA	Substance Abuse and Addiction Recovery Alliance
SAC	State Adolescent Treatment Coordination
S+C	Shelter Plus Care
SACAVA	Substance Abuse Certification Alliance of Virginia
SAMHSA	Substance Abuse and Mental Health Services Administration (U.S.)
SANAP	Substance Abuse Needs Assessment Project
SAPT	Substance Abuse Prevention and Treatment (federal block grant)
SDLC	System Development Life Cycle
SE	Supported Employment
SEC	State Executive Council (of Comprehensive Services Act)
SED	Serious Emotional Disturbance
SERG	State Emergency Response Grant (U.S.)
SEVTC	Southeastern Virginia Training Center (state training center located in Chesapeake)
SGF	State General Funds
SHRC	State Human Rights Committee
SJR	Senate Joint Resolution (also SJ)
SMHA	State Mental Health Authority
SMI	Serious Mental Illness
SMSA	Standard Metropolitan Statistical Area
SNF	Skilled Nursing Facility
SPMI	Serious and Persistent Mental Illness
SPO	State Plan Option (Medicaid)
SRO	Single Room Occupancy
SRO	School Resource Officer
SSA	Social Security Administration (U.S.)
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
State Board	State Mental Health, Mental Retardation and Substance Abuse Services Board
STD	Sexually Transmitted Disease
SUD	Substance Use Disorder (alcohol or other drug dependence or abuse)

SVMHI	Southern Virginia Mental Health Institute (state hospital located in Danville)
SVP	Sexually Violent Predator
SVTC	Southside Virginia Training Center (State training center located in Dinwiddie)
SWG	Structural Work Group (of the Northern Virginia Regional Partnership)
SWVBHB	Southwest Virginia Behavioral Health Board
SWVMHI	Southwestern Virginia Mental Health Institute (state hospital located in Marion)
SWVTC	Southwestern Virginia Training Center (state training center located in Hillsville)
TACID	The Advisory Consortium on Intellectual Disabilities
TANF	Temporary Assistance for Needy Families (federal block grant)
TADBHAC	Terrorism and Disaster Behavioral Health Advisory Council
TB	Tuberculosis
TBI	Traumatic Brain Injury
TC	Training Center (state mental retardation facility)
TDO	Temporary Detention Order
TEDS	Treatment Episode Data Set
TFSASO	Task Force on Substance Abuse Services for Offenders (Virginia)
TIP	Treatment Improvement Protocols (CSAT)
TOVA	Therapeutic Options of Virginia
TRW	Transition to Reinvestment Workgroup (of the SWVBHB)
TWWIIA	Ticket to Work and Work Incentives Improvement Act of 1999
UAI	Uniform Assessment Instrument
UM	Utilization Management
UR	Utilization Review
URICA	University of Rhode Island Change Assessment
U.S.	United States
VA	Veterans Administration (U.S.)
VaACCESS	Virginia Association of Community Rehabilitation Programs
VAADAC	Virginia Association of Alcoholism and Drug Abuse Counselors
VACSB	Virginia Association of Community Services Boards
VACO	Virginia Association of Counties
VADAP	Virginia Association of Drug and Alcohol Programs
VAFC	Virginia Association of Free Clinics
VAFOF	Virginia Federation of Families
VAHA	Virginia Adult Home Association
VAHMO	Virginia Association of Health Maintenance Organizations
VALHSO	Virginia Association of Local Human Services Officials
VANHA	Virginia Association of Nonprofit Homes for the Aging
VASAP	Virginia Alcohol Safety Action Program (Commission on)
VASIP	Virginia Service Integration Program
VASH	Veterans Administration Supported Housing
VATTC	Virginia Addictions Technology Transfer Center
VBPD	Virginia Board for People with Disabilities
VCBR	Virginia Center for Behavioral Rehabilitation (state facility located in Petersburg)
VDEM	Virginia Department of Emergency Management (Virginia)
VDMDA	Virginia Depressive and Manic-Depressive Association
VEC	Virginia Employment Commission (Virginia)
VHHA	Virginia Hospital and Healthcare Association
VHCA	Virginia Health Care Association
VHDA	Virginia Housing Development Authority (Virginia)
VHST	Virginia Human Services Training Center
VICC	Virginia Interagency Coordinating Council
VIACH	Virginia Interagency Action Council on Homelessness

VICH	Virginia Interagency Council on Homelessness
VIPACT	Virginia Institute for Professional Addictions Counselor Training
VITA	Virginia Information Technologies Agency (Virginia)
VITC	Virginia Intercommunity Transition Council
VML	Virginia Municipal League
VNPP	Virginia Network of Private Providers
VOCAL	Virginia Association of Consumers Asserting Leadership
VOPA	Virginia Office for Protection and Advocacy (Virginia)
VPCA	Virginia Primary Care Association
VPN	Virtual Private Network
VR	Vocational Rehabilitation
VRHRC	Virginia Rural Health Resource Center
VVC	Voices for Virginia's Children
WIB	Workforce Investment Board
WRAP	Wellness Recovery Action Plan
WSH	Western State Hospital (state hospital located in Staunton)

Appendix H

Comprehensive State Plan 2008-2014 Reference Documents

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